OMB Approval No. 0985-0018
Expiration 05/31/2010

Implementing the Affordable Care Act: Making it Easier for Individuals to Navigate Their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access

Program Announcement and Grant Application Instructions

U.S. Department of Health & Human Services
FY 2010

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Department of Health and Human Services (HHS)
Administration on Aging and Centers for Medicare & Medicaid Services

Funding Opportunity Title: Implementing the Affordable Care Act: Making it Easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access

Announcement Type: Initial

A. Medicare Improvement for Patients and Providers Act (MIPPA)
Funding Opportunity Number: N/A
Catalog of Federal Domestic Assistance (CFDA) Number: 93.071
Key Dates: The deadline date for submission of applications for all Priorities under this announcement is 11:59 p.m., Eastern Time, on July 30, 2010.
An open information teleconference for applicants of the funding opportunities under this announcement will be held as follows:

- June 29, 2010 at 3PM EST. The toll-free teleconference phone number will be 1-877-267-1577, pass code: 641029

B. ADRC Options Counseling and Assistance Programs
Funding Opportunity Number: HHS-2010-AoA-OC-1025
Catalog of Federal Domestic Assistance (CFDA) Number: 93.048
Key Dates: The deadline date for submission of applications for all Priorities under this announcement is 11:59 p.m., Eastern Time, on July 30, 2010.
An open information teleconference for applicants of funding opportunities B and D under this announcement will be held as follows:

- June 22, 2010 at 3:30 PM EST. The toll-free teleconference phone number will be 1-888-469-1668, pass code: 4536588

C. ADRC Nursing Home Transition and Diversion Programs
Funding Opportunity Number: N/A
Catalog of Federal Domestic Assistance (CFDA) Number: 93.779
Key Dates: The deadline date for submission of applications for all Priorities under this announcement is 11:59 p.m., Eastern Time, on July 30, 2010.
An open information teleconference for applicants of the funding opportunities under this announcement will be held as follows:

- June 23, 2010 at 3:30 PM EST. The toll-free teleconference phone number will be 1-888-469-1668, pass code: 4536588

D. ADRC Evidence-Based Care Transition Programs
Funding Opportunity Number: HHS-2010-AoA-CT-1026
Catalog of Federal Domestic Assistance (CFDA) Number: 93.048
Key Dates: The deadline date for submission of applications for all Priorities under this announcement is 11:59 p.m., Eastern Time, on July 30, 2010.
An open information teleconference for applicants of funding opportunities B and D under this announcement will be held as follows:

- June 22, 2010 at 3:30 PM EST. The toll-free teleconference phone number will be 1-888-469-1668, pass code: 4536588

INTRODUCTION AND OVERVIEW

The Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) will jointly award up to $60 million in formula and competitive grants through this Program Announcement entitled: "*Implementing the Affordable Care Act to make it easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access".*

The Program Announcement combines funding opportunities for states from the following Titles and Sections of The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act now referred to as the *Affordable Care Act*:

Title II - Role of Public Programs

Subtitle E—New Options for States to Provide Long-Term Services and Supports

- Section 2405: Funding for Aging and Disability Resource Centers

Title III - Improving the Quality and Efficiency of Health Care

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

- Section 3306: Funding for Outreach and Assistance for Low Income Programs

AoA and CMS have provided grants to States over the past years to develop person-centered systems of information, counseling and access to make it easier for individuals to learn about and access their health and long-term services and support options. These "one stop shop" programs are known as "Aging and Disability Resource Centers" as well as "No Wrong Door – Single Points of Entry" Programs, and they are designed to serve as "visible and trusted" sources where people can turn to for objective information on their long-term services and support options and their Medicare benefits. These programs also provide "one-on-one" counseling and advice to help consumers, including private pay individuals, to fully understand how available options relate to their particular needs, and – for people who might quality for a public program, the one-stop provides a streamlined eligibility process that covers all publicly funded long-term services and support programs.

Consistent with the original vision outlined in the 2003 ADRC Program Announcement to serve all persons regardless of age, income or disability, funding under this Program Announcement will help States further develop and strengthen their statewide systems of person-centered information, counseling and access. Applications submitted under this Program Announcement should – at a minimum - involve a full partnership of all the state and local agencies that are involved in a State's ADRC network, including the State Unit on Aging, the State Medicaid Agency, State Disability Agencies, State Protection and Advocacy Systems, Area Agencies on Aging, local Medicaid agency, Centers for Independent Living, State Health Insurance Assistance Programs, Benefits Outreach and Enrollment Centers, and other providers of information and referral or long-term services and supports counseling for aging and disability populations.

There are four distinct funding opportunities being made available under this Announcement. The first opportunity makes formula funds available to States, Area Agencies on Aging (AAAs), State Health Insurance Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs) to provide outreach and assistance to Medicare beneficiaries on their Medicare benefits including prevention. The Announcement also includes two competitive funding opportunities that are available to all existing ADRC grantees - one to strengthen ADRC Options Counseling and Assistance Programs, the other to strengthen the role of ADRCs in Evidence-Based Care Transition Models that integrate the medical and social service systems to help older individuals and those with disabilities remain in their own homes and communities after a hospital, rehabilitation or skilled nursing facility visit. Finally, for existing Money Follows the Person state grantees, there is an opportunity to compete for supplemental administrative funds that can be used to strengthen the capacity existing ADRCs to participate in Nursing Home Transitions and Diversions Programs.

The Center for Technology and Aging, with support from the SCAN Foundation, will be making additional funds available to states that are awarded grants under this Announcement for ADRC Evidence-Based Care Transition Programs to support the use of assistive technology in those programs.

This integrated Program Announcement is a model for states to look at realigning their long-term care services and supports systems to better use health care dollars that are consumer focused, efficient and offer a higher quality of care.

Aging and Disability Resource Centers – AoA and CMS Partnership

The opportunities for States, AAAs, SHIPs and ADRCs in this Program Announcement available through the Affordable Care Act further solidify the partnership between AoA and CMS that was first added to the 2006 amendments of the Older Americans Act (OAA).

Title II Section 202b of the OAA (Public Law 109-365) specifically authorizes the Assistant Secretary for Aging to work with the Administrator of the Centers for Medicare and Medicaid Services to: “implement in all states Aging and Disability Resource Centers

> (A) to serve as visible and trusted sources of information on the full range of long-term care options that are available in the community, including both institutional and home and community-based care;
>
> (B) to provide personalized and consumer friendly assistance to empower people to make informed decisions about their care options;
>
> (C) to provide coordinated and streamlined access to all publicly supported long-term care options so that consumers can obtain the care they need through a single intake, assessment and eligibility determination process;
>
> (D) to help people to plan ahead for their future long-term care needs; and

(E) to assist, in coordination with the State Health Insurance Assistance Program, Medicare beneficiaries in understanding and accessing the Prescription Drug Coverage and prevention health benefits available under the Medicare Modernization Act".

Program Announcement 'Buckets' – At a Glance

Grant Section	Funding Source	Agency	Amount	Purpose	Eligible Entities
A	Sec 3306 MIPPA Language	CMS	FY10 – FY12 $15,000,000	MIPPA LIS, MSP, Medicare Part D Outreach, Prevention	State SHIPs - Formula
A	Sec 3306 MIPPA Language	AoA	FY10-FY12 $15,000,000	MIPPA LIS, MSP, Medicare Part D Outreach, Prevention	AAAs and Native American Tribes*
A	Sec 3306 MIPPA Language	AoA	FY10-FY12 $10,000,000	Medicare Part D Outreach	ADRCs Formula
B	Sec 2405	AoA	FY 10 $10,000,000	Expand ADRCs for Options Counseling	States/ADRCs Competitive 20-25 States
C	DRA Sec 6071 CMS (MFP) and AoA Discretionary	AoA/CMS	FY 10 Up to $7,500,000	NH Transitions through Money Follows the Person	Competitive - Up to 16-24 MFP States
D	OAA Title IV AoA and CMS Discretionary	AoA/CMS	FY 10 $2,500,000	Hospital Care Transition Models	Competitive – 5-7 States

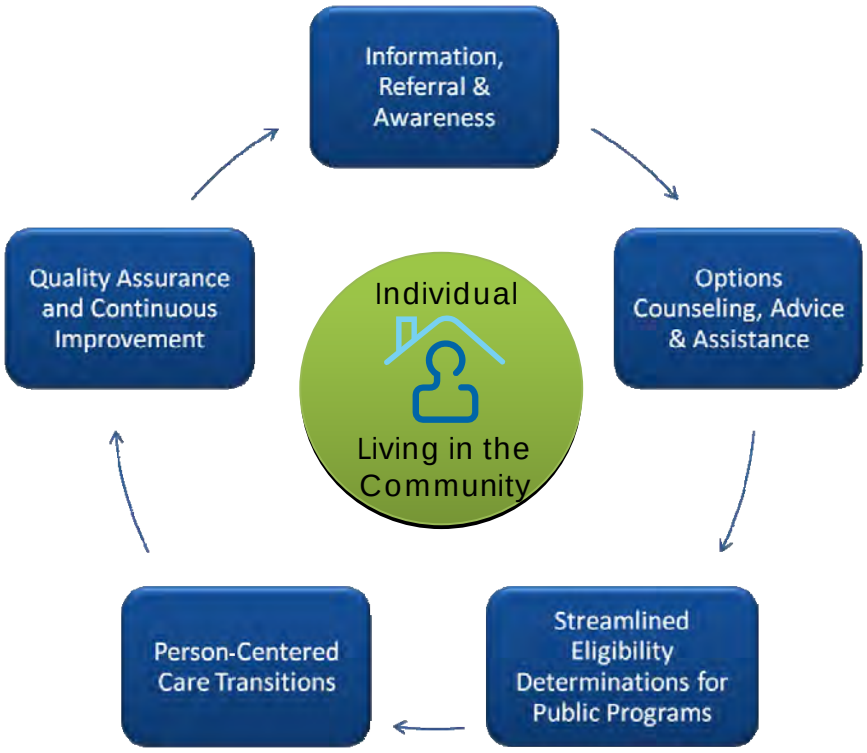
*Native American Tribes will receive funding through a separate RFP process

The AoA/CMS Vision for Aging and Disability Resource Centers

The Administration on Aging and the Centers for Medicare and Medicaid Services (CMS) have awarded over $70 million in grants to 54 States and Territories to date to implement

Aging and Disability Resource Center Programs using a variety of sources including AoA's Title IV Discretionary Grants Program, the CMS Real Choice Systems Change and Money Follows the Person Grant Programs. AoA and CMS's long range vision is to have ADRC programs fully operational and available to individuals in every community

Person-Centered System of Information, Counseling and Access



Aging and Disability Resource Center Functions

across the country serving as highly visible and trusted sources of information on the full range of long-term services and support options along with one-on-one help in understanding and accessing the services and supports they need. ADRCs are community-wide "programs" or "systems" of information, counseling and access; they are not necessarily located in a single physical place, nor are their operational functions necessarily carried out by a single agency or organization. ADRCs can be "networks of State and community organizations" that work together in a coordinated manner to provide consumers with a "single point of entry" to all long-term services and supports, as well as a streamlined process for determining eligibility for all public programs that provide services and supports, either in the community or in an institutional setting. Even though multiple partner organizations will likely be involved in the operation of an ADRC – from the perspective of the consumer, their access to long-term services and supports should be seamless, regardless of what program(s) they may end up using. ADRCs should also help individuals in understanding and accessing their Medicare benefits as well as other public and private programs that promote independence in the community.

The key operational functions of a fully developed ADRC Program include:

- **Information, Referral and Awareness**
- **Options Counseling and Assistance**
- **Streamlined Eligibility Determinations for Public Programs**
- **Person-Centered Care Transitions**
- **Quality Assurance and Continuous Improvement**

ADRCs are now eight years removed from the original inception of the AoA/CMS grant program to States. There are currently over 290 ADRC pilot sites operating - at varying stages of development - across the country covering roughly 45% percent of the U.S. population. The funding opportunities in this program announcement will help States move to more fully developed statewide ADRC programs that reflect the core ADRC operational functions listed above and outlined below.

INFORMATION, REFERRAL AND AWARENESS

The *Information, Referral and Awareness* function of an ADRC is defined by the ADRCs ability to serve as a highly visible and trusted place where people of all ages, disabilities and income levels know they can turn to for objective information on the full range of long-term service and support options. It is also defined by its ability to promote awareness of the various options that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to "plan ahead" for their long-term care. ADRCs should also have the capacity to help individuals be aware of their Medicare benefits and other state and federal programs by partnering with State Health Insurance Assistance Programs (SHIPs) and Benefit Outreach and Enrollment Centers where they exist. Finally, ADRCs should have the capacity to link consumers with needed services and supports – both public and private - through appropriate referrals to other agencies and organizations.

OPTIONS COUNSELING AND ASSISTANCE

The *Options Counseling and Assistance* function is defined by the ADRCs ability to provide counseling and decision support, including one-on-one assistance, to consumers and their family members and/or caregivers. The main purpose of *Options Counseling and Assistance* is to help consumers assess and understand their needs, and to assist them in making informed decisions about appropriate long-term service and support choices – as well as their Medicare options - in the context of their personal needs, preferences, values and individual circumstances. Options Counseling and Assistance also entails helping consumers to develop service plans and arranging for the delivery of services and supports,

including helping individuals to hire and supervise their direct care workers. Individuals and families who receive options counseling should be in better position to make service and support choices that optimally meet their needs and preferences, and be able to make better use their own personal and financial resources in the short term and over time.

STREAMLINED ELIGIBILITY DETERMINATIONS FOR PUBLIC PROGRAMS

Long-term services and supports are funded by a variety of different government programs administered by a wide array of federal, state and local agencies, each with its own eligibility rules, procedures and paperwork requirements. The *Streamlined Eligibility Determinations for Public Programs* component of an ADRC is defined by its ability to serve as a single point of entry to all publicly funded long-term supports, including those funded by Medicaid, the Older Americans Act (OAA), and other state and federal programs and services. This requires ADRCs to have the necessary protocols and procedures in place to facilitate an integrated and/or fully coordinated approach to performing the following administrative functions for all public programs (including both home and community-based services programs and institutional-based programs): consumer intake, screening, assessing an individual's needs, developing service/care plans, determining programmatic and financial eligibility, and ensuring that people receive the services for which they are eligible. The goal is to create a process that is both administratively efficient and seamless for consumers regardless of which program they end of being eligible for or the types of services they receive.

PERSON-CENTERED CARE TRANSITIONS

The Person-Centered Care Transitions component is defined by an ADRCs ability to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payor to another. These pathways include preadmission screening programs for nursing home services and hospital discharge planning programs, and they represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person ends up in a nursing home or is transitioned back to their own home. The ADRC can play a pivotal role in these transitions to ensure that people end up in the settings that best meet their individual needs and preferences, which is often in their own homes. ADRC staff can be present at these critical points to provide individuals and their families with the information they need to make informed decisions about their service and support options, and to help them to quickly arrange for the care and services they choose. These critical activities can help individuals avoid being placed unnecessarily in a nursing home. They can also break the cycle of readmission to the hospital that often occurs when a chronically impaired individual is discharged to the community without the social services and supports they need.

QUALITY ASSURANCE AND CONTINUOUS IMPROVEMENT

Quality Assurance and Continuous Improvement is a part of every ADRC system to ensure adherence to the highest standard of service, as well as to ensure public and private investments in ADRCs are producing measurable results. ADRCs should be using electronic information systems to track their customers, services, performance and costs,

and to continuously evaluate and improve on the results of the ADRC services that are provided to individual consumers and their families, as well as to other organizations in the community. This can include linkages with other data systems, such as Medicaid information systems and electronic health records. The Quality Assurance and Continuous Improvement component of an ADRC should also involve formal processes for getting input and feedback from consumers and their families on the ADRC's operations and on-going development. Every ADRC should have measurable performance goals and indicators related to its visibility, trust, ease of access, consumer responsiveness, efficiency and effectiveness.

OMB Approval No. 0985-0018
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A. The Medicare Improvements for Patients and Providers Act

Program Announcement and Grant Application Instructions

FY 2010

I. FUNDING OPPORTUNITY DESCRIPTION

Statutory Authority

The statutory authority for grants under this program announcement is contained in The Medicare Improvements for Patients and Providers Act of 2008 – Section 119, PL 110-275 as amended by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act).

Description of Funding Opportunities

With the passage of the Affordable Care Act in March 2010, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was amended in Section 3306 to provide additional funding for 2010 through 2012. This legislation builds upon 2008 MIPPA legislation which provided for beneficiary outreach and included funding to State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Center programs (ADRCs), and for a resource center to help coordinate efforts to inform older Americans about available Federal and State benefits available. The 2010 Affordable Care Act provides additional federal funding to be administered by the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) for these outreach and resource center activities.

CMS and AoA are jointly administering the MIPPA funding through a single announcement and a coordinated implementation and monitoring process as a model for similar state and local collaboration for this funding.

SHIPs, AAAs, and ADRCs have successfully filled an important role, providing valuable support at both the state and community levels for organizations involved in reaching people likely to be eligible for the Low Income Subsidy program (LIS), Medicare Savings Program (MSP), Medicare Part D and in assisting beneficiaries in applying for benefits. CMS and AoA seek plans from States that will describe how the 2010 MIPPA funds will be used to enhance those efforts through statewide and local coalition building focused on intensified outreach activities to help beneficiaries understand and apply for their Medicare benefits. Consistent with 2009 MIPPA funding States should provide one coordinated State plan in their application that covers the activities supported by the various funding sources available under MIPPA.

CMS and AoA request that States describe specific project plans to expand, extend, or enhance the outreach efforts to beneficiaries on Medicare Part D and for those with limited incomes. States should describe how the SHIP, AAA and ADRC efforts will be coordinated to provide outreach to beneficiaries with limited incomes statewide, for general Medicare Part D outreach and assistance to beneficiaries in rural areas and for outreach activities aimed at preventing disease and promoting wellness. States are asked to review their MIPPA plans submitted in 2009 and update these plans to reflect successes achieved to date and direct their efforts to enhance and expand their MIPPA outreach activities.

In developing state project plans for MIPPA 2010, States should plan for the statutory changes from MIPPA 2008 that went into effect in 2010. These changes increase

opportunities for local outreach programs. Provided below is information on sections of PL 110-275 which describe these changes. Please note that regulations regarding these changes have not been promulgated.

PL 110 -275; **Section 112: Application of full LIS assets test under Medicare Savings Program (MSP).**

- Amends Section 1905(p)(1)(C) of the Act to equate the MSP asset limit to that of the full Medicare Part D LIS asset limit, effective January 1, 2010. This would increase the MSP resource test to three times Supplemental Security Income (SSI) resource standard indexed by the consumer price index (CPI).

PL 110 -275; **Section 113: Eliminating barriers to enrollment**.

- Amends Section 1144 of the Act to add a new subsection on the Social Security Administration's (SSA) assistance with the MSP and the Medicare Part D - LIS applications. Overall the section requires the Commissioner to provide increased outreach and enrollment support in these processes. For any individual who submits an application for LIS or is identified as potentially eligible for LIS, the Commissioner would be required to provide that individual with information about LIS and MSP, provide a LIS application, and transmit data from the application to the States for purposes of MSP determination.
- Beginning January 1, 2010, requires SSA to transmit "leads data" directly to States, and requires the SSA to coordinate outreach activities with the States in connection with LIS and MSP.
- Leads data transmitted to the States shall be considered by the States as an initiative of an application for benefits under MSP.

In addition, in developing State project plans for MIPPA under the Affordable Care Act, States should plan for the statutory changes that start to go into effect in 2010 which will provide for significant opportunities for beneficiaries. These changes may increase opportunities for local counseling programs and include:

Coverage Gap

In 2010, provides a $250 rebate check for Medicare Part D enrollees who hit the gap in prescription drug coverage known as the 'donut hole'. Beginning in 2011, seniors who reach the donut hole will get a 50 percent discount on brand-name drugs and gradually increasing discounts on generic drugs. The donut hole will be closed completely by 2020. (Title III, Subtitle D, Sec. 3301)

This section amended to include:

- For brand name drugs, requires pharmaceutical manufacturers to provide a 50 percent discount on prescriptions filled in the coverage gap (Effective January 1, 2011), in addition to federal subsidies of 25 percent of the brand name drug cost by 2020 (Phased in beginning January 1, 2013)
- For generic drugs, provides federal subsidies of 75 percent of generic drug cost by 2020 for prescriptions filled in coverage gap (Phased in starting in 2011) (Title I, Subtitle B, Sec. 1101)

Annual Wellness Visit

This section provides coverage under Medicare, with no co-payment or deductible, for an

annual wellness visit and personalized prevention plan services. Services would include a comprehensive health risk assessment; a personalized prevention plan; a list of identified risk factors and conditions and a strategy to address them; and health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition. Effective January 1, 2011. (Title IV, Subtitle B, Sec. 4103) **Note:** Under SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS (MIPPA): (g) The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness.

Low-Income Subsidy (LIS) Improvements
This allows Medicare Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a $0 premium LIS plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3303)

Allows the surviving spouse of an LIS-eligible couple to delay LIS re-determination for one year after the death of a spouse. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3304)

This requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Medicare Part D low-income subsidy plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3305)

Special Needs Plans (SNPs)
Extends the SNP program through December 31, 2013 and requires SNPs to be approved by the National Committee for Quality Assurance (NCQA).

Requires HHS to transition beneficiaries to a non-specialized Medicare Advantage plan or to original fee-for-service Medicare who are enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013.

Medicare Part D Cost Sharing
This section eliminates Medicare Part D cost sharing for people receiving care under a home and community-based waiver who would otherwise require institutional care. (Title III, Subtitle D, Sec. 3309)

Annual Election Period
Starting in 2011 and succeeding years, the annual election period will begin on October 15 and will end on December 7th. (Title III, Subtitle C, Sec. 3204)

MIPPA FUNDING OPPORTUNITIES:

This section describes the various 2010 MIPPA funding opportunities available to State SHIPs, AAAs, and ADRCs. Funds for Native American programs will be carried out under a separate process. In addition, in FY 2010 Congress directed MIPPA resource center

funds to the National Center for Benefits Outreach and Enrollment (NCBOE). These funds will be made available by AoA to the NCBOE through a separate non-competitive process.

1) SHIP: Grants to State SHIPs to provide enhanced outreach to eligible Medicare beneficiaries regarding their benefits and enhanced outreach to individuals who may be eligible for the LIS or for the MSP. A total of $15 million is being made available for this purpose. Anticipated amounts available to each State are listed in **Attachment G**. The amount allocated to a SHIP will be based on two factors. Two thirds of the $15M will be allocated based on the number of Medicare beneficiaries in the State who are likely eligible, but not yet enrolled, for LIS. One third of the $15 million will be allocated based on the number of beneficiaries who are eligible for Medicare Part D and who live in rural areas.

2) AAAs: Grants to State Agencies on Aging for AAAs to provide enhanced outreach to eligible Medicare beneficiaries regarding their benefits and enhanced outreach to individuals who may be eligible for the LIS, MSP, Medicare Part D and Part D in rural areas. A total of $15 million is being made available for this purpose. Anticipated amounts available to each State are listed in **Attachment G**.

3) ADRC: Funding is available for ADRCs to provide outreach to individuals regarding the benefits available under Medicare Part D and under the MSP. Funds will be allocated to State Agencies on Aging via a formula patterned after the statutory formula used for SHIPs and AAAs. A total of $10 million is being made available for this purpose. Anticipated amounts available to each State are listed in **Attachment G**.

1) SHIP, 2) AAA, and 3) ADRC: States awarded grants under the 2010 MIPPA opportunity are requested to direct a portion of the grant funding available to SHIPs, AAAs, or ADRCs to conduct outreach activities aimed at preventing disease and promoting wellness. States are encouraged to be creative in incorporating this outreach activity into their plans and may want to consider integrating these activities with LIS/MSP outreach or developing new and innovative approaches to educating beneficiaries about the new wellness benefits. For example, programs planning outreach to physicians offices to promote LIS and MSP, may want to include additional material on the annual wellness visit and prevention services.

Anticipated funding noted in **Attachment G** is subject to change. Funding amounts will be updated after the application due date if all eligible States and Native American Programs do not apply.

Collaboration

As a condition for receiving funding, States are required to submit one plan for Sections 1 through 3. States should describe how the SHIP, AAA and ADRC efforts will be coordinated to provide outreach to beneficiaries with limited incomes statewide, for general Medicare Part D outreach and assistance to beneficiaries in rural areas, and for outreach aimed at preventing disease and promoting wellness.

Outreach efforts of the SHIP will be coordinated with the related outreach efforts of, AAAs and ADRCs to provide assistance to beneficiaries with limited income for LIS and MSP, and provide general Medicare Part D outreach and assistance on Medicare benefits. Specifically, States should expand their efforts to reach beneficiaries through coordinated efforts.

As a condition for receiving funding, all State agencies participating in this announcement will submit one joint plan that will be signed by each participating State agency. *For example, if the SHIP program is located in the Department of Insurance, and the AAA and ADRC are housed in the State Unit on Aging, two signatures will be required: State Aging Director and Insurance Commissioner.*

As a condition for receiving funds, a State will have to submit for CMS and AoA review and approval a plan documenting their proposed approach to achieving the goals and objectives of this grant program.

States should budget for at least one staff person, preferably the State MIPPA lead, to attend a national meeting in Washington, DC as a part of this effort. It is anticipated that only travel costs (such as airfare and ground transportation) and dinners will need to be covered by the State.

Performance Goals

States are expected to establish and meet measurable performance goals for the various MIPPA funding opportunities. Reports will be the responsibility of one entity designated by the State, e.g. State Unit on Aging or SHIP, if these are separate entities. CMS and AoA will collaboratively review these goals and reserve the right to negotiate revisions based on the State's previous outreach efforts under MIPPA and an analysis of the overall ranges of target goals under this announcement. Each State will submit a plan for approval prior to award.

Performance Goals – Applicant will establish, describe and implement measures, including timeframes, to:

- Distribute funds to AAAs, ADRCs and SHIPs as specified in the grant announcement.
- Establish performance measures with coordinating entities that are performing activities of this grant
- Utilize the NCBOE for technical assistance, and web-based decision support and enrollment tools as appropriate
- Transmit the number of all LIS and MSP applications completed quarterly and the 9 and 24 month performance reports to the NCBOE for tabulation, analysis and evaluation.
- Establish and provide specific information to the NCBOE on the State and local collaborative partnerships.
- While it is not a requirement for funding, we encourage States to coordinate LIS and MSP outreach and enrollment with efforts related to other State and Federal benefits and provide information to, and seek technical assistance from, the NCBOE on any activities in this area.

- Develop the format for and maintain local outreach plans by AAAs, ADRCs and SHIPS.

- Establish overall target for:
  - Number of consumers enrolled in LIS and MSP and the dollar value of benefits received as a result of applications completed;
  - Number and type of LIS/MSP outreach events conducted, including the number conducted in rural areas, during the period, and the number of individuals reached at those events;
  - Number and type of prevention and wellness outreach events conducted, and the number of individuals reached at those events;
  - Number of training and technical assistance sessions held for ADRC, AAA and SHIP programs on outreach, screening, enrollment and follow-up strategies, where the sessions were held, and the number of individuals who participated in these sessions;
  - Number of ADRC, AAA, SHIP programs agreeing to serve as enrollment centers/sites;
  - Number of enrollment events conducted and the number of individuals reached at those events;
  - Additional state performance measures (optional).

Note: AAAs, ADRCs and SHIPs have the option of contracting outreach activities to other community based organizations as necessary.

Note: Based on experience with 2009 MIPPA grants, we anticipate the cost per LIS/MSP application to be over $100.

II. AWARD INFORMATION

PRIORITY AREA	ELIGIBLE APPLICANT	PROGRAM NAME	TOTAL FUNDS AVAILABLE	BUDGET & PROJECT PERIOD
Priority Area 1	Existing State SHIP Grant Recipients	LIS, MSP, and Medicare Part D Outreach, Outreach to Rural Areas and Outreach Activities Aimed at Preventing Disease and Promoting Wellness	$15 million to be awarded by CMS	24 months

Priority Area 2	State Agencies on Aging for AAAs	LIS, MSP, and Medicare Part D Outreach, Outreach to Rural Areas and Outreach Activities Aimed at Preventing Disease and Promoting Wellness	$15 million to be awarded by AoA	24 months
Priority Area 3	State Agencies on Aging for Existing ADRC State Grant Recipients as of March, 2010	Medicare Part D and MSP Outreach and Outreach Activities Aimed at Preventing Disease and Promoting Wellness	$10 million to be awarded by AoA	24 months

MIPPA Priority Areas 1, 2 and 3

Under the MIPPA funding opportunity of this Announcement AoA and CMS will award grants to States by formula. For purposes of this announcement, the definition of a State includes States, Territories and the District of Columbia. The chart in **Attachment G** details the amount of the federal share for each State for a 24 month project period. The anticipated start date for these projects is September 30, 2010. All States are eligible to apply for Priority Areas 1 and 2. Only States that have an AoA and CMS funded Aging and Disability Resource Center are eligible to apply for funds under Priority 3. Total federal funding available under each of the three areas is as follows:

- 1 - SHIPs - $15 million total to provide outreach to individuals who may be eligible for LIS/MSP, outreach on Medicare Part D to beneficiaries in rural areas and outreach activities aimed at preventing disease and promoting wellness.

- 2 -AAAs - $15 million total to provide outreach to individuals who may be eligible for LIS/MSP, outreach on Medicare Part D to beneficiaries in rural areas, and outreach activities aimed at preventing disease and promoting wellness. ***(Funding for Native American Programs are deducted from Priority 2 and are being allocated through a separate process.)***

- 3 -ADRCs - $10 million total to States with ADRC sites in existence as of March, 2010 to provide outreach to individuals regarding benefits available under Medicare Part D and MSPs and outreach activities aimed at preventing disease and promoting wellness.

III. ELIGIBILITY INFORMATION

Eligible Applicants
MIPPA Priority Areas 1, 2 and 3: Awards made under this announcement, by statute, will be made only to agencies of State Governments.

Priority 1: Only existing SHIP grant recipients are eligible to apply.

Priority 2: Only State Agencies on Aging are eligible to apply. (Allocation of funds for Native American Programs is being accomplished through a separate process.)

Priority 3: Only State Agencies on Aging that received an AoA and CMS Aging and Disability Resource Center (ADRC) grant where the ADRC was established by March, 2010.

Cost Sharing or Matching

MIPPA Priority Areas 1, 2 and 3
Cost sharing does not apply. Please disregard any reference to "AoA Required Match" found in the Attachments.

An open information teleconference for applicants of this solicitation will be held **June 29, 2010 from 3PM-4PM EST**. The toll-free teleconference phone number will be **1-877-267-1577, Pass code: 641029**

IV. APPLICATION AND SUBMISSION INFORMATION

Address to Request Application Package
Application materials are also available by writing to:

U.S. Department of Health and Human Services
Administration on Aging
Greg Case
Office of Home and Community-Based Services
Washington, D.C. 20201
greg.case@aoa.hhs.gov

Content and Form of Application Submission
Do not submit plans via www.grants.gov. Applications should be submitted via e-mail to grants.office@aoa.hhs.gov .

The following documents are required as a part of the application for 2010 MIPPA funding:

- Cover Page: Template attached as **Attachment F**
- SF 424
- Responses to the questions below will constitute the State plan narrative

- Detailed Budget Narrative/Justification (See **Attachment B**)

SHIP/AAA/ADRC Outreach Funds

Each funded entity is required to complete and separately respond to questions 1-10. The funded entities must jointly prepare a response for the four collaborative questions. State responses should represent an update to your 2009 MIPPA plan. Please describe the activities your State intends to undertake above and beyond activities previously detailed in the 2009 MIPPA plan or Basic SHIP Grant Application.

1. a. Will all funds provided for LIS, MSP outreach and assistance efforts be used solely to support outreach and assistance efforts directed toward Medicare beneficiaries with limited incomes who may be eligible for LIS or MSP programs? (Yes or No – Note that an answer of Yes is required to be eligible for funding.)

   b. Will a portion of the funds be directed toward Medicare beneficiaries for outreach aimed at preventing disease and promoting wellness?

2. a. Will all activities described by the SHIP to reach people likely eligible for LIS or MSP programs be above and beyond those regular activities that the SHIP has planned in response to funding provided under the Basic SHIP Grant Award? (Yes or No – Note that an answer of Yes is required to be eligible for funding.) If yes, please describe how this supplemental funding will extend or enhance the LIS or MSP outreach and assistance efforts that you will provide in response to the Basic SHIP Grant Award funding.

   b. Will all activities described by the AAA or ADRC to reach people likely eligible for LIS/MSP programs be above and beyond activities funded under the 2009 MIPPA award? If yes, please describe how this funding will extend or enhance these activities.

3. Will your State use county and zip code specific data provided by CMS or AoA to target efforts related to reach beneficiaries who are likely eligible, but not enrolled for LIS, MSP or State Prescription Assistance Programs? If yes, please indicate how that data will be used to target the outreach and assistance efforts of the SHIP. If no, please indicate how the State will identify and target people who are likely eligible, but not enrolled for LIS, MSP, or SPAP programs?

4. How will the State use the funding to enhance or expand application assistance available in communities with beneficiaries who are likely eligible, but not enrolled for LIS or MSP programs? (Examples – recruiting and training counselors placed in low-income neighborhoods or communities, training community-based organizations that serve low-income beneficiaries to provide application assistance, establishing new local counseling sites in low-income communities, etc)

5. a. What specific activities will the State use to conduct outreach likely to persuade beneficiaries who are likely eligible, but not enrolled in LIS or MSP to apply for one or both of these programs? (Example – direct mail, outreach events, public and

media activities, door-to-door outreach). Please be specific about the State outreach plan.

b. What specific activities will the State use to conduct outreach likely to persuade beneficiaries to participate in disease prevention and wellness activities? We encourage States to think creatively about how they can encourage beneficiaries to take advantage of the new wellness and prevention benefits. How can you integrate these outreach activities with LIS/MSP or other outreach? What new innovative activities focused on prevention and wellness might be implemented?

6. a. Will the State establish or expand partnerships that will enable the State to reach and/or provide application assistance to people who are likely eligible, but not enrolled in LIS or MSP programs or who may be eligible for prevention or wellness activities? (Yes or No) If Yes, what specific partnerships will the State establish or expand and what populations (described either geographically or demographically) will the partnership allow the State to reach? What specific activities will result from the partnership?

   b. Where applicable, how will the State coordinate with the Native American programs on LIS, MSP, Medicare Part D or prevention and wellness outreach?

SHIP/AAA/ADRC Rural Medicare Part D Outreach Funds

7. Will all funds provided for rural outreach to Medicare Part D eligible beneficiaries be used to reach and assist people who live in rural areas and who are eligible for Medicare Part D? (Yes or No – Note that an answer of Yes is required to be eligible for funding.)

8. Will all the activities described by the State to reach Medicare Part D eligible beneficiaries in rural areas be above and beyond those regular activities that the State has planned in response to other funding, e.g. Basic SHIP Grant Award, OAA outreach, or MIPPA 2009 outreach? (Yes or No – Note that an answer of Yes is required to be eligible for funding.)

9. What specific activities will the State use to conduct outreach likely to reach beneficiaries living in rural areas with information about Medicare Part D coverage and the associated LIS/MSP programs for beneficiaries with limited incomes? (Example – direct mail, outreach events, public and media activities)

10. How will the State use the funding to enhance or expand application assistance available in rural areas of the State? (Examples – recruiting and training counselors deployed to serve rural areas, training community-based organizations that serve beneficiaries living in rural areas, establishing new local counseling sites in rural areas, etc)

State Questions – Collaborative Efforts

1. What are the quantifiable outcome targets of the collaborative efforts of the SHIP, AAAs and ADRCs to reach and provide application assistance to beneficiaries who

are likely eligible, but not enrolled in LIS, MSP and/or Medicare Part D programs and how will the effort be measured? For example, the State may propose to generate a target number of applications for these programs and track those applications through a specific data system or tool. Please do not state the targets in terms of a number of outreach events or counseling sessions, but rather in terms of a number of applications submitted or another quantifiable target that will demonstrate progress in getting more beneficiaries enrolled in these programs.

2. How will the State measure and report progress toward the stated outcome target?

3. What specific work plan will the State utilize to coordinate the efforts of the SHIP, AAAs and ADRC that are funded under this program to assure that work is collaborative, that resources of the programs are leveraged to provide maximum effectiveness, and that work is not duplicative?

4. Please provide a timeline for the 24 month duration of this grant that will outline the planned activities of the SHIP, AAA, and ADRC programs and the anticipated progress toward achieving the goal the State outlined in response to Question 1 of this section.

Please provide a detailed budget narrative that supports the State plan as described in the responses to the questions above.

Submission Dates and Times
The deadline for the submission of State plans for 2010 MIPPA awards described under this program announcement is July 30, 2010. Plans must be submitted electronically by 11:59pm midnight Eastern Time to grants.office@aoa.hhs.gov.

An open information teleconference for applicants of this solicitation will be held **June 29, 2010 from 3PM-4PM EST**. The toll-free teleconference phone number will be **1-877-267-1577, Pass code: 641029**

Intergovernmental Review
This funding opportunity announcement is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs"

Identify any activities which are not fundable under the grant program, e.g., construction and/or major rehabilitation of buildings. This section also may include any other types of funding restrictions, e.g., ceiling amounts for particular activities if an application will consist of multiple programmatic components. This section should also indicate whether pre-award costs are allowable.

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings
- Basic research (e.g. scientific or medical experiments)
- Continuation of existing projects without expansion or new and innovative approaches

V. APPLICATION REVIEW INFORMATION

MIPPA Funding Opportunity

Plans for funding under MIPPA as amended by the Affordable Care Act will be reviewed by AoA and CMS based on the requirements of the Program Announcement. AoA and CMS will contact applicants to negotiate any questions or concerns before issuing a Notice of Award.

VI. AWARD ADMINISTRATION INFORMATION

Award Notices

MIPPA Priority Areas 1, 2, and 3
Priority Area 1: SHIPs - Successful applicants will receive an official Notice of Award (NoA), signed by the CMS Grants Management Officer (GMO) that will set forth the amount of the award and other pertinent information, along with a set of Terms and Conditions for fulfillment of the grant specific to the individual award. The NoA is the legal document issued to notify the grantee that an award has been made and that funds may be requested from the Department of Health and Human Services (DHHS) designated payment system or office. This NoA will be sent through the U.S. Postal Services. All successful applications will be awarded using CFDA 93.779.

Priority Areas 2 and 3: AAAs and ADRCs - Successful applicants will receive an electronic Notice of Award for AAA funding and an electronic Notice of Award for ADRC funding. The Notice of Award is the authorizing document from the Administration on Aging authorizing official, Grants Management Office, and the AoA budget office.

Awards will be made by 9/29/2010 with an anticipated start date of 09/30/2010.

Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement located at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm.

Reporting

2010 MIPPA
A single consolidated report on the performance measures established by each State will be due to CMS and AoA at the end of the first 9 months following award and again at the end of the 24 month project period. Instructions for submitting these reports via the NCBOE reporting tool will be sent to grantees after awards have been made.

A separate SF-269 (Financial Status Report) is due annually and is required for each Notice of Award received under 2010 MIPPA funding authority. These reports are to be submitted directly to CMS and AoA.

VII. AGENCY CONTACTS

AoA MIPPA Project Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
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CMS SHIP MIPPA Grants Management Specialist
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VIII. OTHER INFORMATION

The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, collection of information unless it displays a currently valid OMB control number.

The project description and Budget Narrative/Justification is approved under OMB control number 0985-0018 which expires on 5/31/10.

Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

OMB Approval No. 0985-0018
Expiration 05/31/2010

B. ADRC Options Counseling and Assistance Programs

Program Announcement and Grant Application Instructions

U.S. Administration on Aging
FY 2010

Department of Health and Human Services (HHS)
Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services

Announcement Type: Initial
Funding Opportunity Number: HHS-2010-AOA-OC-1025
Catalog of Federal Domestic Assistance (CFDA) Number: 93.048

Key Dates:

Open Information Teleconference:	June 22, 2010, 3:30 PM EST
Teleconference Number:	1-888-469-1668, pass code: 4536588
Recorded Call-back #	
(To listen to recorded teleconference)	1-888-873-4963, pass code: 4536588
Voluntary Notice of Intent to Apply:	July 1, 2010
Grant Application Due Date:	July 30, 2010
Issuance of Notice of Grant Awards:	Prior to September 30, 2010
Grant Period Start Date:	September 30, 2010

Funding Opportunity:

Award Type:	**Cooperative Agreement**
Federal funds available:	A**pproximately $10 million**
Est. Number of Awards:	A**pproximately 20 to 25**
Project Start Date:	**Sept 30, 2010**
Eligible Applicants:	**One State Agency or instrumentality of a State from any State that received an AoA or CMS ADRC or Hospital Discharge Planning Grant Award between fiscal years 2003 and 2009 (see next section, Eligibility Information, for more details)**
Est. Total Award:	A**pproximately $500,000 for 24-month period**
Project Period Length:	**24 months**
Budget Periods Length:	T**wo 12-month budget periods**

I. FUNDING OPPORTUNITY DESCRIPTION

1. Statutory Authority

The statutory authority for grants under this Program Announcement is contained in SEC. 2405 of the Patient Protection and Affordable Care Act, and Titles II and IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365. (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects).

Title II Section 202b specifically authorizes the Assistant Secretary for Aging to work with the Administrator of the Centers for Medicare and Medicaid Services to: “implement in all States Aging and Disability Resource Centers –

> (A) to serve as visible and trusted sources of information on the full range of long-term care options that are available in the community, including both institutional

and home and community-based care;

(B) to provide personalized and consumer friendly assistance to empower people to make informed decisions about their care options;

(C) to provide coordinated and streamlined access to all publicly supported long-term care options so that consumers can obtain the care they need through a single intake, assessment and eligibility determination process;

(D) to help people to plan ahead for their future long-term care needs; and

(E) to assist, in coordination with the State Health Insurance Assistance Program, Medicare beneficiaries in understanding and accessing the Prescription Drug Coverage and prevention health benefits available under the Medicare Modernization Act".

Patient Protection and Affordable Care Act SEC. 2405. Funding To Expand State Aging and Disability Resource Centers. Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, $10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 3012).

2. Background and Vision

The Administration on Aging in collaboration with the Centers for Medicare and Medicaid Services has awarded grants to ADRC programs in 54 States and Territories since 2003, through a variety of programs including AoA's Title IV Discretionary Grants Program, the CMS Real Choice Systems Change and Money Follows the Person Grant Programs. Under this Program Announcement, AoA in collaboration with CMS is making funds available for States to significantly strengthen the ADRC's Options Counseling and Assistance function.

Many consumers and their families experience frustration and challenges when turn to the formal system for help. They are often confronted with a bewildering maze of agencies and organizations offering services and supports with differing eligibility criteria, application processes, and cost sharing requirements. ADRCs have a unique opportunity to meet people at times of critical decision-making and help them short through this maze of information and options. The ADRC Options Counseling function is specifically designed to help individuals regardless of their age, income or disability to understand the full range of services and supports available in their community, evaluate how those options relate to their particular needs and circumstances, and make informed decisions about obtaining and managing the options that best meet their needs, either with their own private resources and/or through one or more public or private programs. The ADRC Options Counseling function also helps to ensure people actually end up receiving the care they choose.

Staying consistent with the original vision outlined in the first ADRC program announcement, this announcement builds on the foundation of an ADRC's strong

Information, Referral and Awareness function. As originally described in each ADRC announcement since 2003, Options Counseling and Assistance is designed to be a person-centered decision support process that helps consumers regardless of their age, income or disability and their families in a variety of settings and situations. It may occur during an initial needs assessment, upon discharge from a hospital, or in support of a transition back into the community after a long-term nursing facility stay. It can also assist individuals regardless of their age, income or disability who do not have an immediate need for help but wish to plan ahead for their long-term independence. Because of its applicability across the spectrum of the long-term service and support system, the Options Counseling and Assistance function distinguishes ADRCs as true "one-stop" systems, where all consumers can get the support they need in one place even as their needs change.

The individuals who provide options counseling at ADRCs are specially trained to counsel and advise consumers and their families across ages and disabilities. ADRC option counselors can also serve as support brokers in publicly funded participant-directed programs, such as Cash and Counseling, helping the participants to decide what goods and services will best suit their needs and preferences, and how best to manage the delivery of the services and supports, including determining whether or not to directly hire and supervise their own workers.

As the ADRC initiative has grown and expanded across the country, States have taken different approaches to the delivery of Options Counseling. Recognizing that States lacked a clear and common understanding of this service, the National Association of State Units on Aging (NASUA) worked with grantees, AoA and other Technical Assistance (TA) partners in 2007 to build consensus in the field around the following definition of options counseling:

> ***Options Counseling Definition -*** *An interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term support choices in the context of the consumer's needs, preferences, values, and individual circumstances.*

Building on NASUA's 2007 white paper, *Long-Term Support Options Counseling: Decision Support in Aging and Disability Resource Centers,* the Technical Assistance Exchange (TAE) initiated a work group of eight grantee states to identify core competencies of options counseling and discuss training standards.[1] Drawing from the input of this work group and Wisconsin's work in the area of options counseling in particular, the TAE developed curriculum for three training programs for program planners and front line staff: The Art of Options Counseling: Interactive Workshop for Program Planners and Managers, The Art of Options Counseling (for front-line staff), and Advanced Art of Options Counseling: The Core Competencies Explored and Experienced. Archived recordings and materials from these trainings are available online at http://www.adrc-tae.org/tiki-index.php?page=Training. These curricula list six core competencies of options counseling:

[1] NASUA, *Long-Term Support Options Counseling: Decision Support in Aging and Disability Resource Centers*, January 2007, available online at: http://www.adrc-tae.org/tiki-download_file.php?fileId=29257

1. Determining the need for options counseling

2. Assessing needs, values and preferences

3. Understanding public and private sector resources

4. Demonstrating respect for self-direction / determination

5. Encouraging orientation toward planning for the future

6. Following up

While progress has been made building a common understanding of what options counseling means, there are still different standards in place across States that guide who receives options counseling and under what circumstances, what options counseling entails, who is qualified to provide options counseling and what kind of training they receive, and how options counseling is evaluated and performance measured. For example, in some ADRCs options counseling is offered by specially trained counselors with advanced degrees in social work or nursing. In other ADRCs, options counseling is offered by staff with bachelors degrees or equivalent experience who also provide information and referral services as part of their day-to-day job duties. Some ADRCs consider options counseling an extension of information and referral and offer it to any caller who indicates a need for more in-depth decision support. In others, options counseling is triggered when an individual begins the application process for a public program. Collectively, ADRC programs report that options counseling may be offered through I&R/A, SHIP counseling, pre-admission screening for nursing facilities, during the comprehensive assessment process for public programs, and in support of nursing facility transition. However, not all ADRCs offer it systematically in all of these situations.

3. Funding Opportunity

Consistent with the original vision of ADRCs to serve all persons regardless of age, income or disability, Options Counseling and Assistance is a critical function of ADRCs that requires special skills and should be recognized as an important area of professional practice. Establishing common standards that states and the federal government can use to guide the delivery of Options Counseling across ADRCs and across States will help distinguish it as a specialized service and strengthen the capacity of the ADRC network overall. With this vision in mind, this grant opportunity will support State projects to strengthen, develop and/or implement a comprehensive set of standards they can use to guide, monitor and continually improve the delivery of Options Counseling and Assistance within the context of their ADRC systems. These funds will help States to standardize options counseling delivery policies and procedures, identify and invest in staff training and preparation, and implement common client tracking procedures for assessing the performance of Options Counseling across their ADRCs. This grant is also intended to produce a set of minimum national standards for ADRC Options Counseling and Assistance that AoA will use to guide, monitor and continually improve the ADRC program nationwide. Specifically, AoA seeks to bring together States awarded grants under this Announcement, and other stakeholders, in a collaborative process to further define the parameters of options counseling (i.e. where it begins and ends and how it intersects with

other ADRC functions), establish core competencies for options counselors, and develop a comprehensive set of minimum national standards the ADRC Options Counseling and Assistance Program.

AoA plans to convene a diverse group of States and ADRC stakeholders to participate in the process of developing minimum national standards for Options Counseling. This will ensure applicability of the new minimum standards in different regions of the country, within the rules and regulations of different State service systems, and within the context of different ADRC models. For example, ADRCs that are operated by a network of organizations (the "no wrong door" model) may legitimately have different expectations for what Options Counseling should entail across partners and target populations. AoA seeks a set of national minimum standards for Options Counseling and Assistance that specifically addresses the differences in the populations of people ADRCs serve and accounts for differences in the structure and staffing of different ADRC operating organizations. The final product of the collaborative process may outline minimum core competencies across populations and settings as well as areas for potential specialization, such as options counseling for individuals with dementia and their caregivers.

Elements of a comprehensive set of standards for the ADRC Options Counseling, for purposes of this Announcement include:

a. Goals, Objectives and Subject Areas to be Covered by Options Counseling Standards. Subject areas include:

- Existing Long-Term Services and Support Options;
- Planning Ahead for One's Long-Term Care;
- Selecting and Managing Consumer-Directed Services and Supports;
- Medicare Benefits and Options; and/or
- Other Services and Benefits.

b. Target Populations and Geographic Coverage

c. Staffing Requirements

- Core Competencies
- Training
- Staffing Ratios

d. System Requirements

- Administration and Management
- Data and Information Systems

e. Partnerships Requirements

f. Continuous Quality Improvement and Evaluation

4. Grant Activities Timeline and Deliverables.

Staying consistent with the original vision outlined for ADRCs in 2003, grantees will engage in two distinct yet interrelated activities over the grant period:

1) Develop and implement, in at least one ADRC site, a comprehensive set of standards (or strengthen/refine existing standards) for the ADRC Options Counseling and Assistance function.

2) Participate in a collaborative process with other grantees, federal agency staff, TA providers and other stakeholders to develop a set of minimum national standards for Options Counseling and Assistance.

Grantees will spend the first year of the grant period developing, refining and implementing – in a least one ADRC site - a comprehensive set of standards for their ADRC Options Counseling Program that address the elements noted above in section 3. The standards should specify how options counseling will be delivered, by whom, to whom, under what circumstances, and how it will be tracked and outcomes monitored. They should also specify the credentials and training required for options counselors and set minimum staffing ratios. Grantees with existing standards for options counseling may refine or strengthen their standards (e.g. add person-centered planning training requirement), expand their options counseling programs into new settings (e.g. pre-admission screening for nursing facilities) and/or build capacity for providing options counseling to specific populations (e.g. people with physical/intellectual/developmental disabilities).

Ideally, States will implement these new standards statewide, but, at a minimum, they should be implemented in at least one ADRC site within the first 12 months of the grant period. Grantees will carry out training (as needed) so that options counselors in their implementation sites meet the new standards. To meet this requirement, grantees may design or adapt their current training programs to meet the standards or use national training programs that are approved by AoA. Over the second year of the grant, grantees will monitor and track delivery of options counseling to evaluate the impact of the new standards in terms of business operations (e.g. effectiveness of referral protocols, client to staff ratios) and consumer outcomes (e.g. greater sense of empowerment, satisfaction with service and support choices made, integration into the community). Grantees will collect feedback from options counselors and stakeholders about the process of implementing the standards and analyze preliminary service delivery and outcomes data for inclusion in a final report.

Meanwhile, grantees also will participate in a collaborative process with other grantees, federal agency staff, TA providers, and other stakeholders to define a set of minimum national standards for the delivery of options counseling, including core competencies, minimum qualifications required for options counselors, and protocols for client tracking and performance measurement. From each State, primary participants in the collaborative process must include State staff from the agency or agencies that oversee and administer the ADRC network, ADRC program managers and options counselors. Activities of this core group of participants will include regular teleconference calls/webinars and attendance at two national conferences over the grant period. As part of the collaborative process, participants may be asked to present information about their options counseling programs to the group, participate in sub-committees on specific topics, and review and

provide feedback on materials and resources the group develops. States should also be prepared to invite staff from State or regional Medicaid offices (unless already represented), information and referral specialists, consumer representatives, and other community partners and stakeholders to participate in select group activities. Federal agencies and AoA's Technical Assistance Exchange and partners including The Lewin Group, National Association of State Units on Aging, National Council on Independent Living, National Resource Center on Participant-Directed Services, National Council on Aging, National Association of Area Agencies on Aging National Association of States Directors of Developmental Disabilities Services and the National Association of State Mental Health Program Directors will be represented in this collaborative effort, and other stakeholder organizations such as the Alliance for Information Referral Systems, will be invited to participate in the process. When this group reaches consensus on the key components of the minimum national standards for options counseling, grantees may need to adjust to their own standard operating procedures to meet the minimum standards.

At the end of the grant period, grantees will prepare and submit a final report that:

1) Summarizes feedback gathered from program managers, options counselors and other stakeholders about the process of developing and implementing their comprehensive set of standards for their ADRC Options Counseling and Assistance Program;
2) Summarizes evaluation findings about service delivery and consumer outcomes (over a period of at least 6 months);
3) Outlines a plan for implementing the standards statewide, including a recruitment and/or training plan for ensuring all options counselors across the State meet minimum qualifications, by 2015; and
4) Specifies the different funding streams to be used to pay for Options Counseling going forward.
5) Methods used to involve programs funded by the federal government through the Administration on Developmental Disabilities; Substance Abuse and Mental Health Services Administration; Rehabilitation Services Administration of the U.S. Department of Education Independent Living Program in specific activities related to Options Counseling.

Funds May be Used To:

1. Support the participation of State staff, local ADRC staff, partners, consumers and other stakeholders in the process of developing State-specific standards for ADRC Options Counseling.
2. Implement the standard operating procedures statewide or in at least one ADRC site.
3. Provide training for new or existing options counselors to meet the new standards.
4. Expand options counseling services to a new population or into a new setting or situation.
5. Modify existing IT/MIS client tracking systems and protocols as needed to meet new Options Counseling standards.
6. Gather and analyze service delivery and consumer outcomes data.
7. Gather feedback from ADRC staff and stakeholders about their experience with the new standards to contribute toward future improvement and refinement.
8. Support the participation of State staff, local ADRC staff, partners, consumers and

other stakeholders in collaborative process of establishing minimum national standards for options counseling (regular conference calls and two in-person conferences).

Key Deliverables:

1. A comprehensive set of State-specific standards for ADRC Options Counseling and Assistance that addresses the elements listed above in Section 3. Funding Opportunity.
2. Implementation of new standards in a least one ADRC, including training options counselors (as needed)
3. Evaluation plan (to be implemented in second year of grant)
4. Active participation in the collaborative process to develop national standards.
5. Attendance at two national meetings
6. Semi-Annual Reporting
7. Final Report

Partnerships

Consistent with the original requirements outlined in the original ADRC Program Announcements, applications submitted under this Program Announcement must – at a minimum - involve a full partnership of all the state and local agencies that are involved in a State's ADRC network, including the State Unit on Aging, the State Medicaid Agency, State Disability Agencies, State Protection and Advocacy Systems, Area Agencies on Aging, local Medicaid agency, Centers for Independent Living, State Health Insurance Assistance Programs, Benefits Outreach and Enrollment Centers, and other providers of information and referral or long-term services and supports counseling for aging and disability populations. Grantees are encouraged to involve professional associations ADRC staff are affiliated with, such as the Alliance of Information and Referral Systems, and state or national associations of social workers or nurses.

ADRC Options Counseling grantees will be expected to meet the following key deadlines:

Activity/Deliverable	Deadline
State-specific standard operating procedures for ADRC options counseling	Due to AoA 6 months after award
Implementation of new standards including training (as needed)	By 12 months after grant award
Evaluation plan	Due to AoA 12 months after grant period
Active participation in the collaborative process to develop minimum national standards	Over the entire duration of the grant
Attendance at two national meetings	One per year, dates to be determined
Semi-Annual Reports	Due to AoA every six months as part of regular ADRC Semi-Annual Reporting process
Final Report	Due to AoA three months after grant period ends

II. AWARD INFORMATION

Award Type:	**Cooperative Agreement**
Federal funds available:	**Approximately $10 million**
Est. Number of Awards:	**Approximately 20 to 25**
Project Start Date:	**Sept 30, 2010**
Eligible Applicants:	**One State Agency or instrumentality of a State from any State that received an AoA or CMS ADRC or Hospital Discharge Planning Grant Award between fiscal years 2003 and 2009 (see next section, Eligibility Information, for more details)**
Est. Total Award:	**Approximately $500,000 for 24-month period**
Project Period Length:	**24 months**
Budget Periods Length:	**Two 12-month budget periods**

Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. AoA/CMS reserves the right to offer a funding level that differs from the requested amount, including amounts less than the amount the applicant has requested. AoA reserves the right to defer applications for consideration in future fiscal years, as funds may not be available to support all proposals

These grants will be issued as Cooperative Agreements because AoA, in collaboration with CMS, anticipates having substantial involvement with the recipients during performance of funded activities. For additional information on the level of AoA's and grantee involvement as outlined in the Cooperative Agreement please see **Attachment H**. Grantees will be expected to maintain regular contact with their federal project officer and to cooperate with the AoA and CMS Technical Assistance Centers. Grantees will also be expected to share all significant products and activities with AoA and CMS.

Once a cooperative agreement is in place, requests to modify or amend it or the work plan may be made by AoA or the awardee at any time. Modifications and/or amendments of the Cooperative Agreement or work plan shall be effective upon the mutual agreement of both parties, except where AoA is authorized under the Terms and Conditions of award, 45 CFR Part 74 or 92, or other applicable regulations or statutes to make unilateral amendments.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Only a State agency or instrument of a State from a State that: 1) received an award to implement ADRCs through the AoA and CMS ADRC grants funded in fiscal years 2003, 2004, 2005 and 2009, and/or the CMS Person-Centered Hospital Discharge Planning Model Grants funded in fiscal years 2008 and 2009 may apply for this funding opportunity; and 2) continues to implement and operate the ADRC activities funded through their grant award(s), may apply for this funding opportunity. **AoA will accept only one application per State**. The applicant

agency must have the support and active participation of the State Unit on Aging, the Single State Medicaid Agency, and State Disability Agencies where applicable. "State" refers to the definition provided under 45 CFR 74.2.

Executive Order 12372 is not applicable to these grant applications.

2. Cost Sharing or Matching

Matching funds are not required. Please disregard any reference to "AoA Required Match" found in the Attachments.

Please note, applications that include any form of match will **not** receive additional consideration under the review. Match is not one of the responsiveness criteria as noted in Section III, 3 Application Screening Criteria.

3. Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the screening criteria described below will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

A. Applications must be submitted electronically via http://www.grants.gov by 11:59 p.m., Eastern Time, July 30, 2010.

B. The Project Narrative section of the Application must be **double-spaced**, on 8 ½" x 11" plain white paper with **1" margins** on both sides, and a **font size of not less than 11**.

C. **The Project Narrative must not exceed 10 pages**. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel **are not counted** as part of the Project Narrative for purposes of the 10-page limit.

4. Application Responsiveness Criteria

Again, to assure a level playing field for all applicants, applications that fail to meet the following responsiveness criteria will **not** be reviewed and will receive **no** further consideration:

A. Applicant is a State Agency or instrumentality of the State (e.g., State Unit on Aging, State Medicaid Agency, State Disability Agencies);

B. Applicant has received an award to implement ADRCs through the AoA and CMS ADRC grants funded in fiscal years 2003, 2004, 2005 and 2009, and/or the CMS Person-Centered Hospital Discharge Planning Model Grants.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx.

Contact person regarding this Program Announcement:

U.S. Department of Health and Human Services
Administration on Aging
Joseph Lugo
Office of Planning and Policy Development
Washington, D.C. 20201
joseph.lugo@aoa.hhs.gov

Please note, AoA is requiring applications for all announcements to be submitted electronically through http://www.grants.gov. The Grants.gov (http://www.grants.gov) registration process can take several days. If your organization is not currently registered with http://www.grants.gov, please begin this process immediately. **For assistance with http://www.grants.gov, please contact them at** support@grants.gov **or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website (http://www.grants.gov).

Applications submitted via http://www.grants.gov:

- You may access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (**HHS-2010-AoA-OC-1025**) or CFDA number (93.048).
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. AoA strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.
- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the http://www.grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- **Your application must comply with any page limitation requirements**

described in this Program Announcement.

- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.govthat contains http://www.grants.gov tracking number. The Administration on Aging will retrieve your application form from http://www.grants.gov.
- After the Administration on Aging retrieves your application form from http://www.grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://www.grants.gov.
- Each year organizations registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (http://www.ccr.gov).

2. Content and Form of Application Submission

A. Letter of Intent

To apply for this funding opportunity, AoA strongly recommends that applicants submit a "letter of intent" via email or voice mail to assist AoA in planning for the application independent review process. The deadline for submission of the "letter" is July 1, 2010.

U.S. Department of Health and Human Services
Administration on Aging
Joseph Lugo
Office of Planning and Policy Development
Washington, D.C. 20201
E-mail: Joseph.lugo@aoa.hhs.gov

B. DUNS Number

The Office of Management and Budget requires applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements on or after October 1, 2003. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.

Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf **.**

C. Project Narrative

AoA will not accept applications with a Project Narrative that exceeds 10 pages. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. The Project Work Plan, Letters of Commitment, and Vitae of Key Personnel are not counted as part of the Project Narrative for purposes of the 10-page limit, but

all of the other sections noted below are included in the limit.

The components counted as part of the 10 page limit include:

1. Summary/Abstract
2. Proposed Project
    a. Current Status and Overall Approach
    b. Goals, Objectives and Subject Areas to be Covered by Options Counseling Standards
    c. Target Populations and Geographic Coverage
    d. Staffing Requirements
    e. System Requirements
    f. Partnerships Requirements
    g. Continuous Quality Improvement and Evaluation
3 Organizational Capacity
4. Project Management and Stakeholder Participation

The Project Narrative should provide a **clear and concise** description of your project and it is the most important part of the application because it will be used as the primary basis to determine whether or not your project meets the review criteria. AoA recommends that your project narrative include the following components:

1. Summary/Abstract. This section should include a brief description of the proposed activities including: the goal(s) and objectives, expected outcomes – 265 word maximum.

2. Proposed Project

a. Current Status and Overall Approach

Successful applicants will offer a candid assessment of their current standards for their ADRC Options Counseling, addressing each of the elements for a comprehensive set of standards as noted above in Section 3. Funding Opportunity.

Successful applicants will clearly describe the basis and rationale for the overall approach they are proposing to take to develop and implement a comprehensive set of standards for their ADRC Options Counseling Program in at least one of their ADRCs and then evaluating the impact of those standards within the timeframes of this grant. This should include a description of the major challenges the State will face and the strategies and tactics the State will deploy be successful in implementing the proposed project.

Even though the specifics of the new standards to be implemented will evolve and may change as program level staff, partners and other stakeholders are brought into the development process, applicants are asked

to describe – at least in general terms - the nature of the new State standards that will be implemented under this grant, based on their current vision for how Options Counseling should be offered across the State.

b. Goals, Objectives and Subject Areas to be covered by the ADRC Options Counseling Standards

Successful applicants will describe the goals and objectives of their Options Counseling Program and the subject areas to be covered under its standards for the program. The types of subject areas may include but not be limited to:

- Existing Long-Term Services and Support Options
- Planning Ahead for One's Long-Term Care
- Selecting and Managing Consumer-Directed Services and Supports
- Medicare Benefits and Options
- Other Services and Benefits

c. Target Populations and Geographic Area

Successful applicants will clearly describe the various consumer groups and populations and the geographic areas to be covered in the site where the standards will be implemented. Applicants will also describe how the plan to reach their proposed target populations with their Options Counseling Program. The target population should be described in terms of:

- age
- type of disability (e.g. adults with physical/intellectual/ developmental disabilities)
- income level (e.g. private paying)
- setting or circumstance (e.g. individuals applying for nursing facility services)

d. Staffing Requirements

Successful applicants will clearly describe their current staffing standards and how these will change under the new/revised standards in each of the following areas:

- Credentials
- Training
- Numbers Served and Consumer to Staff (Case Load) Ratios

Applicants will also describe how their standards will ensure that options counselors are prepared to serve the ADRC's different target populations in the proposed settings and circumstances.

e. System Requirements

Successful applicants will clearly describe the various systems requirements that will be addressed by their standards that will ensure the effective and efficient implementation of ADRC Options Counseling, both within the ADRCs that will be involved in the proposed grant program, and eventually statewide. Systems standards that must be addressed by the applicant in this section include at a minimum:

- Standards for Administrative and Management
    - What standards, tools, resources, or protocols are currently used to guide and support the delivery of options counseling?
    - What tools or protocols will be developed to better manage options counseling delivery?
- Data and Information Systems
    - What IT/MIS developments or enhancements will be necessary to track options counseling services and consumer outcomes over time?

f. Partnership Requirement

In concert with the original vision outlined for ADRCs in 2003, successful applicants will clearly delineate the formal agreements and protocols that ADRC Options Counseling Programs will be required to have in place with other agencies, organizations and stakeholder groups. This section will include a description of the strategies and tactics the State's standards will plan to incorporate to ensure a standardized approach to options counseling across an ADRC's network.

g. Continuous Quality Improvement and Evaluation

Successful applicants will describe the performance measures, indicators and data elements ADRCs would be required to collect and track as part of the new SOPs for Options Counseling. Successful applicants will describe how they currently track service delivery, track consumer outcomes, and monitor program quality and the specific tools, management information systems, and methods that ADRCs would use to do this going forward. In addition, applicants should describe their plan for evaluating the process of implementing the new standards, including gathering feedback from participating program managers and options counselors, and document preliminary outcomes from the first year of implementation, including the impact of the new standards on business operations and consumer outcomes.

3. Organizational Capacity. Applicants should describe the experience/performance of the ADRCs that will be involved in the

development, implementation and evaluation of the new State SOPs. Experience/performance may include length of time in operation, number of individuals served, accomplishments and any noteworthy performance indicators related to options counseling (e.g. percent of ADRC clients receiving options counseling, consumer satisfaction rates, ratio of home and community based service referrals vs. institutional placement). Applicants should describe the capacity and qualifications of key State and local staff to participate in the development, implementation and evaluation of new State standards as well as national minimum standards. Organizational charts and vitas will not count towards the narrative page limit.

4. Project Management and Stakeholder Participation. Applicants should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. It should specify who will have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, participation in collaborative process to develop national minimum standards; preparation of reports; communications with partner agencies and key stakeholders, and AoA. Applicants should specify the roles that the State Medicaid Agency, the State Agency on Aging, the State Disability Agency(ies), the State Insurance Assistance Program, the State Protection and Advocacy Systems, the Area Agencies on Aging, the Centers for Independent Living and other disability organizations will play in this project and in the development of the State-specific operating procedures? How will ADRC program staff, consumers and other stakeholders be involved in the project?

D. Work Plan

Applicants should provide a realistic timetable and work plan that outlines the extent to which they will be able to complete each activity within the 24 month project period as well as a description of how each activity will contribute to the overall goals and objectives of the program and to the system changes described in the Announcement.

The Project Work Plan should reflect and be consistent with the Project Narrative and Budget and should cover both years of the project period. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks / action steps that will be pursued to achieve the goal and outcome(s). For each major task / action step, the work plan should identify the timeframes involved (including start- and end-dates), and the lead person responsible for completing the task. Please use the Sample Work Plan format included in the Attachments.

E. Letters of Commitment from Key Participating Organizations and Agencies

Applicants should include confirmation of the commitments to the project should it be funded) made by key collaborating organizations and agencies.

This should include at a minimum letters of commitment from the directors of: 1) State Unit on Aging, 2) State Medicaid Agency, 3) State Disabilities Agencies where applicable, as well as letters from participating ADRCs; SHIP programs, and Benefit Outreach and Enrollment Centers (where applicable). For applications submitted electronically via http://www.grants.gov, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the AoA Office of Grants Management at 202-357-3466 no later than the application submission deadline.

F. Budget Narrative/Justification

The Budget Narrative/Justification should be provided using the format included as an attachment of this Program Announcement. Applicants are encouraged to pay particular attention to Attachment B, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required. Applicants should also ensure that funds are delineated for at least four representatives to attend two ADRC meetings/events during each of the two years of the overall project period.

3. Submission Dates and Times

Applicants are requested, but not required, to submit a letter of intent to apply for this funding opportunity. The letter of intent assists AoA in planning for the independent review process of the applications. The deadline for submission of letters of intent is July 1, 2010.

The deadline for the submission of completed applications under this program announcement is July 30, 2010. Applications must be submitted electronically at http://www.grants.gov by 11:59 p.m. Eastern Time, July 30, 2010. Applications that fail to meet the application due date will **not** be reviewed and will receive **no** further consideration.

Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in Grants.gov. After the Administration on Aging retrieves your application form from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov

An open information teleconference for applicants of this solicitation will be held June 22, 2010 at 3:30 p.m., EST. The toll-free teleconference phone number will be 888-469-1668, pass code: 4536588.

4. Intergovernmental Review

This funding opportunity announcement is not subject to the requirements of Executive Order 12372, “Intergovernmental Review of Federal Programs.”

5. Funding Restrictions

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings;
- Basic research (e.g. scientific or medical experiments); and,
- Continuation of existing projects without expansion or new and innovative approaches.

V. APPLICATION REVIEW INFORMATION

Criteria

Applications are scored by assigning a maximum of 100 points across four criteria:

A. Current Program Status and Proposed Approach - (50 points);

B. Organizational Capacity - (20 points).

C. Project Management and Stakeholder Participation - (20 points).

D. Work Plan and Budget – (10 points);

A. Current Program Status and Proposed Approach Weight: 50 points

i. Does the applicant demonstrate a clear understanding of the goal of this Program Announcement and its relevance to their state and community needs? Does the application adequately describe the current status of their ADRC options counseling program, document the key problems or conditions the State intends to address through this grant, and does the application provide a clear indication of the types of standards the State plans to develop and implement relative to the elements of a comprehensive set of standards for ADRC Options Counseling Programs that are described in this Announcement in sections 3. *Funding Opportunity and Part C. Project Narrative*. Are the expected project benefits/results clear, realistic, and consistent with the objectives and purpose of the project? (20 points)

ii. Does the applicant articulate a coherent plan for addressing the identified problems and achieving the identified outcomes? Does the applicant make a strong case that standardizing, strengthening and/or expanding their options counseling program in the way they propose will benefit consumers in the community? Does the applicant show meaningful involvement of agencies and organizations that represent various populations with disabilities in the on-going operations of their ADRC Options Counseling Program? Do they offer adequate explanation for choosing to expand options counseling into the new populations or new settings? Do they clearly outline how and where the standards will be implemented and how their impact will be tracked and evaluated? Does the plan include the qualitative and/or quantitative methods necessary to reliably measure outcomes? Does the applicant take into account barriers and opportunities that exist in the larger environment that may impact on the project's success?

(30 points)

B. Organizational Capacity **Weight: 20 points**

i. Do the proposed project director(s), key staff and consultants have the background, experience, and other qualifications required to carry out their designated roles? Do the organizations who will implement the new options counseling standards have the experience and capacity necessary to implement and evaluate new SOPs within the timeframe of this grant project? Are letters from participating organizations included, as appropriate, and do they express a clear commitment to the collaborative process and a willingness to make changes to their current options counseling protocols and procedures across various aging and disability organizations? Are the areas of responsibility of those organizations consistent with the work plan description of their intended roles and contributions? (20 points)

C. Project Management and Stakeholder Input **Weight: 20 points**

i. Does the proposal include a clear and coherent management plan? Are the roles and responsibilities of project staff, consultants and partners clearly defined and linked to specific objectives and tasks? (10 points)

ii. Does the application describe a feasible approach for meaningfully involving ADRC staff and other stakeholders in the development and implementation of the State-specific standards as well as in the national minimum standards? Are all the key partnering agencies and potential stakeholders included? (10 points)

D. Work Plan and Budget **Weight: 10 points**

i. Does the work plan include sensible and feasible timeframes for the accomplishment of tasks presented? Does the work plan include specific objectives and tasks that are linked to measurable outcomes? (5 points)

ii. Are budget line items clearly delineated and consistent with work plan objectives? Is the budget justified with respect to the adequacy and reasonableness of resources requested? Is the time commitment of the proposed director and other key project personnel sufficient to assure proper direction, management and meaningful engagement in the project? (5 points)

Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria if applicable. These reviewers are experts in their field, and are drawn from academic institutions, non-profit organizations, state and local government, and Federal government agencies. Based on the Application Review Criteria as outlined under section V.1, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance;

the reasonableness of the estimated cost to the government considering the available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

Applicants have the option of omitting from the application specific salary rates for individuals specified in the application budget.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration on Aging authorizing official, Officer of Grants Management, and the AoA Office of Budget and Finance. Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement, located at:
http://www.hhs.gov/grantsnet/adminis/gpd/index.htm.

3. Reporting

The SF-269 (Financial Status Report) is due annually and the AoA program progress report is due semi-annually. Final performance and SF-269 reports are due 90 days after the end of the project period. For more information on this process, please see **Attachment M** of this solicitation on Measurable Performance Goals.

Instructions for annual financial and semi-annual program performance reports will be included with the award packets sent to successful applicants. An original and two copies of the financial report and the AoA program progress report are requested. Awardees will receive instructions for both reports with their Notice of Financial Assistance Award. Final performance and financial reports are due 90 days after the end of the project period. For more information see DHHS / AoA Standard Terms and Conditions.

Grantees are required to submit a quarterly Federal Cash Transaction Report (SF-272) to the Payment Managements System as identified in their award documents for the calendar quarters ending 3/31, 6/30, 9/30, and 12/31 through the life of their award. In addition, a Financial Status Report (SF-269) will be required as denoted in the Notice of Award. Please Note: HHS is transitioning to the combined Federal Financial Report (FFR) known as the SF-425, which will replace the Financial Status SF-269 and Federal Cash Transaction Report SF-272. HHS/AOA will provide further guidance implementing the use of the new form at a later date.

VII. AGENCY CONTACTS

Project Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Joseph Lugo
E-mail: Joseph.lugo@aoa.hhs.gov

Grants Management Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Margaret Tolson
E-mail: margaret.tolson@aoa.hhs.gov

VIII. OTHER INFORMATION

Application Elements

SF 424 – Application for Federal Assistance (See Attachment A for Instructions).

SF 424A – Budget Information. (See Attachment A for Instructions).

Separate Budget Narrative/Justification (See Attachments B and C for a Budget Narrative/Justification Sample Format with Examples and a Sample Template).

NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding.

SF 424B – Assurances. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

Lobbying Certification

Proof of non-profit status, if applicable

Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

Project Narrative with Work Plan (See Attachment D for Sample Work Plan Format).

Organizational Capability Statement and Vitae for Key Project Personnel.

Letters of Commitment from Key Partners.

The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

The project description and Budget Narrative/Justification is approved under OMB control number 0985-0018 which expires on 5/31/10.

Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

OMB Approval No. 0985-0018
Expiration 05/31/2010

C. ADRC Nursing Home Transition and Diversion Programs

Program Announcement and Grant Application Instructions

Center for Medicare & Medicaid Services
FY 2010

Department of Health and Human Services (HHS)
Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services

Announcement Type: Initial
Funding Opportunity Number: N/A
Catalog of Federal Domestic Assistance (CFDA) Number: 93.779

Key Dates:

Open Information Teleconference:	June 23, 2010, 3:30 PM EST
Teleconference Number:	1-888-469-1668, pass code: 4536588
Recorded Call-back # (To listen to recorded teleconference)	1-866-435-5406, pass code: 4536588
Voluntary Notice of Intent to Apply:	July 1, 2010
Grant Application Due Date:	July 30, 2010
Issuance of Notice of Grant Awards:	Prior to September 30, 2010
Grant Period Start Date:	September 30, 2010

Funding Summary:

Award Type:	**Supplemental Award (CMS MFP funds)**
Federal funds available:	**Approximately $7.5 million**
Est. Number of Awards:	**Approximately 16 to 24**
Project Start Date:	**Sept 30, 2010**
Eligible Applicants:	Existing MFP grantees in **Money Follows the Person (MFP) Demonstration States**
Est. Total Award:	**Approximately $400,000 for 24-month period**
Project Period Length:	**24 months**
Budget Periods Length:	**Two 12-month budget periods**

Awards will be granted under this funding opportunity as supplemental grant awards to existing MFP grantees. MFP grantees will be invited to submit a supplemental budget request to their CMS Project Officer, which will in turn, be reviewed by both AoA and CMS for approval. The supplemental request must adhere to the above submission schedule and address all of the objectives outlined in this funding announcement.

MFP States granted a supplemental budget award will be required to submit an Operational Protocol amendment. Amendments to the Operational Protocol with regard to this funding opportunity are subject to both the approval of the CMS Project Officer and the AoA Project Officer overseeing the ADRC initiative within the MFP State.

Awardees will be expected to maintain regular contact with their CMS Project Officer and to cooperate with the AoA and CMS Technical Assistance and Evaluation contractors. Grantees will also be expected to share with and report to AoA and CMS on all significant products and activities. Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. AoA and CMS reserve the right to offer a funding level that differs from the requested amount, including amounts less than the amount the applicant has requested.

Of note, the activities outlined under this funding opportunity will be made available to

new and existing MFP grantees at a later date—both in the form of initial demonstration awards and supplemental grant awards, respectively. This funding opportunity offers immediate funding for activities related to expanding the capacity of ADRCs to assist with MFP transition efforts in the State, including partnering on the implementation of the newly-revised Minimum Data Set (MDS) 3.0.

I. FUNDING OPPORTUNITY DESCRIPTION

1. Statutory Authority

The statutory authority for grants under this Program Announcement is contained in The Money Follows the Person Rebalancing Demonstration Act Feb. 8, 2006, P.L. 109-171, Title VI, Subtitle A, Ch. 6, Subch. B, § 6071, 120 Stat. 102, and in Titles II and IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365. (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects)

2. Background

Despite increasing use of home and community-based services, the organization, financing, and delivery of Medicaid-funded long-term care services remains biased towards institutional care. Recognizing the challenges, States face in rebalancing their LTC systems, AoA and CMS have funded numerous grant and demonstration opportunities to assist States' efforts in promoting community-based options as an alternative to institutional care. Since 2003, AoA and CMS have awarded more than $70 million to assist 54 States and Territories to:

- Provide information, referral, and assistance related to community long-term care options through the development of Aging and Disability Resource Centers (ADRCs);
- Build community-based long-term care infrastructure and capacity through CMS Real Choice Systems Change Grants; and,
- Promote long-term care rebalancing and build transition programs through the Money Follows the Person Demonstration.

ADRCs have played a critical role in building community-based capacity and infrastructure, developing formal linkages with nursing facilities and hospitals, and facilitating care transitions that optimize community living opportunities for chronically impaired individuals.

Money Follows the Person Demonstration

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of the Deficit Reduction Act (DRA) of 2005, States were provided new options to rebalance their long-term support programs to allow their Medicaid programs to be more sustainable while helping individuals achieve independence. The DRA reflects a growing consensus that long-term supports must be

transformed from being institutionally-based and provider-driven to "person-centered" and consumer-directed. The DRA provisions reflected a long-awaited commitment to independence, choice, and dignity for countless Americans who want to live and receive long-term care services in their own homes and communities.

Section 6071 of the DRA, the "Money Follows the Person Rebalancing Demonstration," is a major component of a comprehensive, coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems. A total of $1.75 billion was appropriated to States to support their efforts in:

- Rebalancing their long-term support systems so that individuals have a choice of where they live and receive services;
- Transitioning individuals from qualified institutions who want to live in the community; and,
- Promoting a strategic approach to implement a system that provides person-centered planning, delivery of quality services, development of new services that promote successful transition into the community and total community reintegration, improve each participant's quality of life and create quality management systems that continuously improve care and promote better health outcomes.

At this time, MFP Rebalancing Demonstrations are being implemented in 29 States and the District of Columbia. However, the Affordable Care Act amends the language of Section 6071 of the Deficit Reduction Act of 2005 (DRA) to authorize the extension of the program with funding through 2016. The following are the changes in Section 6071 of the DRA included in Section 2403 of the Affordable Care Act that provide for the extension of this important rebalancing demonstration:

- Extends the MFP Rebalancing Demonstration Grant program with any of the remaining $1.75 billion available through 2016 and by adding the additional years to the program allows for awarding of additional MFP grants to States;
- The minimum period a resident must reside in an institution is reduced from six months to a period of not less than 90 consecutive days with one exception; if the individual is residing in the institution having been admitted solely for the purpose of receiving short-term rehabilitation services which payment for those services is limited under Medicare. Those days will not count toward the 90 day MFP required institutional period; and,
- Provides for additional funding through 2016 for the National MFP Evaluation.

Nursing Home Minimum Data Set 3.0

An essential component of nursing home transition efforts is assertive identification of nursing home residents who prefer a home or community-based setting to an institutional setting. State agencies report that they experience difficulty in identifying Medicaid residents in nursing homes who wish to be discharged to a community setting. One potential way to strengthen these efforts is to more effectively use federally-mandated

nursing home resident assessment tools.

The Long-Term Care Minimum Data Set (MDS) Version 2.0 is currently mandated by CMS and requires that all residents in Medicare and/or Medicaid-certified nursing homes be assessed according to the prescribed instrument. The federally-mandated MDS tool has been recognized as a potential targeting tool for identifying individuals for transition into the community.

Effective October 1, 2010 CMS will be requiring the implementation of a newly-revised MDS—Version 3.0. Revisions to the tool have dramatically altered Section Q, with the Section now requiring nursing home staff to directly ask residents about their desire to speak with someone regarding community-living options. The revised Section also requires nursing homes to make referrals to local contact agencies[2] so they can help educate residents interested in community-living about available community-based care options. The local contact agencies will be responsible for contacting residents, discussing options, and assisting interested residents to return to the community.[3]

CMS has identified ADRCs and other organizations as possible local contact agency options for States preparing to implement the MDS 3.0 tool in October 2010. The ADRCs are well-positioned to help States respond to the increase in demand for transitions that is likely to be generated from health care reform and the new MDS assessment tool.

ADRC – MFP Partnerships

The ADRC initiative has expanded into every State, D.C. and several Territories, and since the program's inception ADRCs have been working to assist individuals in making important decisions about their long-term care. In many States, ADRCs serve as the single entry point to public services and supports. With additional funding from AoA and CMS over the last few years, ADRCs have strengthened their capacity to provide information, assistance and options counseling to people of all ages, all disability types, and all income levels.

Many ADRCs have established strong relationships with the nursing homes and other institutions in their communities. They provide information, assistance, and options counseling to residents and their caregivers, as well as inform facility staff about new community programs. Some ADRCs, through their partnerships with Centers for Independent Living, are already directly involved in nursing home transition work. Other examples of partnerships between ADRCs and State MFP programs include:

1. **New Hampshire**: The ADRCs in New Hampshire (ServiceLink Resource Centers) are the primary referral and access agents for the State's MFP initiative; and,
2. **Maryland**: The Department of Mental Health and Hygiene (the MFP awardee) funded the expansion of the ADRC program so that ADRC staff can better support transitions across the state. Currently, ADRC staff provide options counseling for

[2] Local contact agencies can include, but are not limited to: Aging and Disability Resource Centers, Centers for Independent Living, Area Agencies on Aging, State Developmental Disability agencies, and/orState Mental Health agencies.

3 For more information on Section Q in the new MDS 3.0, see http://www.taformfp.com/training.aspx?id=1792

nursing facility residents during face-to-face visits, helping them to make informed decisions on how they wish to proceed. For some it is a choice to remain in the nursing facility; for others it provides them with linkages to the supports necessary to pursue discharge to the community.

3. 2010 Funding Opportunity Description

The primary goal of this opportunity is to facilitate and strengthen the roles of ADRCs in coordinating transitions from nursing homes to community based settings for older adults and people with disabilities or chronic conditions. Specifically, AoA and CMS are interested in promoting increased partnership between State MFP programs and ADRCs to advance transition work within the MFP demonstration.

Under this Program Announcement, funds are being made available to existing state MFP grantees in the form of administrative supplement awards to strengthen ADRC roles in:

1. Building ADRC infrastructure and capacity to support transition efforts within MFP program;
2. Promoting partnering activities between the State Medicaid Agency, State Unit on Aging, State Disability Agency, State and local Ombudsman program and other relevant stakeholders; and,
3. Preparing for and continually supporting the implementation of the MDS 3.0, Section Q.

It is expected that the funding under this program announcement will help ADRCs that are currently involved in MFP initiatives expand their efforts; encourage MFP programs that have not yet partnered with ADRCs to begin collaborative work; and, help advance federal transition initiatives.

Due to the fact ADRCs have different funding, capacity, and partners, ADRCs might serve different roles within the various demonstration States. In the supplemental budget request, States must clearly describe the role that ADRCs are expected to play in the transition work including the activities to be performed by the State and the Local Ombudsman program. Successful applicants will formally engage ADRCs in one or more of the following roles:

- **Screening, identifying, and assessing** persons who are potential candidates for transition to a home or community setting or who could remain in the community with appropriate and cost effective supports;
- **Providing options counseling** to individuals on supports available in the community to both those who transition out of an institution and those considering institutional placement;
- **Establishing a service plan** and providing coordination services;
- **Facilitating implementation of services plans and access** to available and accessible home- and community-based services for transitioning;
- **Establishing / strengthening quality assurance and continuous**

improvement processes to monitor success in transitions and improve program effectiveness;

- **Strengthening infrastructures to facilitate transitions** by enhancing databases and directories of resources and providers, building or linking with worker registries of independent providers, and/or building or linking with housing registries;
- **Providing education/outreach/marketing to state agency staff and nursing home staff** on the implementation of the MDS 3.0 Section Q.

During the grant period, the ADRCs involved in this initiative will be encouraged to work with AoA and CMS through a collaborative process with other grantees, federal agency staff, TA providers and evaluation contractors to define a core set of expectations for the on-going role of ADRCs in the MFP program. Those expectations may include: core competencies for ADRC staff involved in transition coordination, protocols for working with individuals seeking information about returning to the community, client tracking, and performance measurement.

Staff from the agency or agencies that oversee and administer the ADRC network and local ADRC program managers will be invited to participate in this collaborative process. Activities of this core group of participants will include participation in regular teleconference calls/webinars and attendance at two national conferences over the grant period. As part of the collaborative process, participants may be asked to present information about their transition programs to the group, participate in sub-committees on specific topics, and review and provide feedback on materials and resources the group develops. To the extent possible, states should also include staff from state or regional Medicaid offices (unless already represented), consumer representatives, and other community partners and stakeholders in select group activities.

Reporting

AoA and CMS will not require any new reporting processes for grantees under this funding opportunity. However, AoA and CMS will make minor adjustments to the current reporting processes for ADRC and MFP grantees, respectively, to capture information related to the goals and objectives of this funding opportunity. For example, the semi-annual report template currently required of State MFP programs may add additional text boxes to report on their formal partnerships with ADRCs and the number of individuals transitioned into the community as a result of the MDS 3.0 Section Q tool.

Use of Grant Funds

Supplemental awards will be given to existing MFP States that demonstrate their ability to address the goals and objectives outlined in this funding opportunity. MFP States are expected to formally partner with ADRCs, with the ultimate goal being to increase the capacity of ADRCs with regard to transition functions.

AoA and CMS encourage States to direct a minimum of 60% of its grant award to the ADRC network agencies (i.e. AAA, CILs, Ombudsman) in order to carry out the goals and objects of this grant. Due to the nature of the actives performed by these agencies State Medicaid agencies can choose to direct addition funds beyond the required 60%.

Relevant ADRC activities that may be paid for through supplemental grant funds include,

but are not limited to:

- Identifying Medicaid-eligible individuals interested in discharge to the community from an institution and individuals at high risk of an extended institutional placement
- Educating individuals and facility staff about community-based long-term care options
- Providing options counseling related to receiving services in the community
- Supporting individuals through the discharge process from nursing facilities, ICF-MRs, and hospitals by working directly with individuals and by partnering with staff of these facilities to establish community supports. This may include:
    - Identifying affordable, accessible housing and linking individuals to such resources
    - Teaching individuals to be their own advocates as they deal with all of the people involved in a transition
    - Teaching individuals the skills necessary for them to live in the community
    - Helping individuals to identify community resources
    - Assisting with paperwork
    - Helping individuals find appropriate personal assistants or nursing care
    - Ensuring all assistive devices are available and in place
    - Helping individuals access resources for minor home modifications, when necessary
- Maintaining a relationship with individuals and following up to ensure adequate supports are in place after a return to the community
- Developing or enhancing protocols to execute the tasks associated with MFP and other institutional transition/diversion initiatives (including those above)
- Partnering with public housing authorities and other organizations to link individuals to the housing they need to return to the community
- Executing data use agreements necessary to share MDS data
- Training ADRC staff and Ombudsman programs personnel on person-centered planning or other core competency skills directly related to MFP and other institutional transition/diversion initiatives
- Building data systems and the management infrastructure necessary to implement MFP and other institutional transition/diversion activities

The award may be used to cover costs necessary to implement the activities described above or other activities consistent with the objectives of this funding opportunity.

II. AWARD INFORMATION

Award Type:	**Supplemental Award (CMS MFP funds)**
Federal funds available:	**Approximately $7.5 million**
Est. Number of Awards:	**Approximately 16 to 24**
Project Start Date:	**Sept 30, 2010**
Eligible Applicants:	Existing MFP grantees in **Money Follows the Person (MFP) Demonstration States**
Est. Total Award:	**Approximately $400,000 for 24-month period**
Project Period Length:	**24 months**

Budget Periods Length: **Two 12-month budget periods**

Awards will be granted under this funding opportunity as supplemental grant awards to existing MFP grantees. MFP grantees will be invited to submit a supplemental budget request to their CMS Project Officer, which will in turn, be reviewed by both AoA and CMS for approval. The supplemental request must adhere to the above submission schedule and address all of the objectives outlined in this funding announcement.

MFP States granted a supplemental budget award will be required to submit an Operational Protocol amendment. Amendments to the Operational Protocol with regard to this funding opportunity are subject to both the approval of the CMS Project Officer and the AoA Project Officer overseeing the ADRC initiative within the MFP State.

Awardees will be expected to maintain regular contact with their CMS Project Officer and to cooperate with the AoA and CMS Technical Assistance and Evaluation contractors. Grantees will also be expected to share with and report to AoA and CMS on all significant products and activities. Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. AoA and CMS reserve the right to offer a funding level that differs from the requested amount, including amounts less than the amount the applicant has requested.

Of note, the activities outlined under this funding opportunity will be made available to new and existing MFP grantees at a later date—both in the form of initial demonstration awards and supplemental grant awards, respectively. This funding opportunity offers immediate funding for activities related to expanding the capacity of ADRCs to assist with MFP transition efforts in the State, including partnering on the implementation of the newly-revised Minimum Data Set (MDS) 3.0.

III. ELIGIBILITY INFORMATION

Eligible Applicants

Only agencies that received MFP awards from CMS in 2007 may apply for this funding opportunity. (See **Attachment I** for a list of eligible agencies). The applicant must have the support and active participation of the state agency or instrument of the state that currently has or in past received an award to implement ADRCs.

Executive Order 12372 is not applicable to these grant applications.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Content and Form of Application Submission

Project Narrative

AoA/CMS will not accept applications with a Project Narrative that exceeds 5 pages. The Letter of Commitment does not count as part of the Project Narrative for purposes of the page limit, but all of the other sections noted below are included in the limit.

The components counted as part of the page limit include:

1. Summary/Abstract
2. Current Status of State's ADRC Program(s) and Current Status of the MFP-ADRC Partnership
3. Goals, Objectives, and Outcomes
4. Proposed Project
5. Project Management

The Project Narrative is the most important part of the application because it will be used as the primary basis to determine whether or not your proposal meets the review criteria. The Project Narrative should provide a **clear and concise** description of your project. AoA recommends that your project narrative include the following components:

1. **Summary/Abstract.** This section should include a brief - no more than 265 words maximum - description of the proposed project, including: the goal(s) and objectives, and a description of how the applicant will use this funding to strengthen the role of ADRCs in MFP initiatives.

2. **Current Status of ADRC and MFP-ADRC Partnership:** This section should describe the current capacity and coordination of the ADRC(s) participating in this initiative to support MFP and MDS 3.0 Section Q implementation. Clearly and concisely describe the length of time that ADRCs have been operating in the state, the populations they serve, the types of agencies operating the ADRCs (e.g., AAAs, Centers for Independent Living), and their core functions. This section could include discussion of the extent to which ADRCs already work with nursing facilities and institutions in the state and any involvement or experience ADRCs have with nursing facility diversion and transition programs. This section should include a brief description of the extent to which the agencies operating the MFP and ADRC programs are currently coordinating their activities. The applicant could briefly describe the processes and systems the MFP program uses to help Medicaid beneficiaries transition to the community from nursing facilities, ICF/MRs and other institutional settings. The description should describe the role of the ADRCs in these processes, and how, if at all, they are involved in MFP transition work.

3. **Goals, Objectives, and Outcomes:** Applicants should describe the proposed project's goals and objectives, including any challenges or barriers they expect this collaboration will help them overcome. Include specific targets relevant to your proposed initiative, such as the number of additional institutional residents who will receive counseling about their options or the number of additional people you plan to assist to transition to the community with the support of ADRCs. Specify any products, tools, resources, MOUs or protocols to be

developed. Please distinguish clearly between the expected outcomes under your current MFP program and those expected as a result of the work funded by this award.

4. **Proposed Project:** This section should provide a clear and concise description of the ways in which you will meet the goals and objectives of this funding opportunity. It should include brief descriptions of:

    - How the funds will be used to build ADRC infrastructure and capacity to support MFP implementation;
    - How the project will strengthen partnerships between state agencies in support of state balancing initiatives;
    - How the collaboration will help the state prepare for and implement the MDS 3.0 Section Q;
    - The consumer populations that will be targeted and how they will benefit from the involvement of ADRCs in MFP activities; and
    - The geographic area of the state where the collaboration activities will be implemented.

Applicants should describe how the project activities build on current work within the State and fit with other related initiatives and how the collaboration will be sustained after Federal grant funding has ended.

5. **Project Management**. Applicants should include a clear delineation of the roles and responsibilities of project staff with the State MFP Program and those at the participating ADRCs, plus any consultants and partner organizations directly relevant to the project. This section should identify challenges and barriers that might arise through this collaboration and how these will be addressed.

Letter of Commitment: Applicants must provide a letter of commitment as part of their applications from either the existing ADRC grantee agency and or previous awardees' of an ADRC grant.

2. Submission Dates and Times

The deadline for the submission of completed applications under this program announcement is July 30, 2010. Applicants must submit applications to their CMS MFP Project Officer by 11:59 p.m. Eastern Time, July 30, 2010.

CMS MFP Project Officer:
U.S. Department of Health and Human Services
Center of Medicare & Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850
Attn: Sarah Fogler,
E-mail: Sarah.Fogler@CMS.hhs.gov

An open information teleconference for applicants of this solicitation will be held June 23, 2010 at 3:30 p.m., EST. The toll-free teleconference phone number will be 888-469-1668, pass code: 4536588.

3. Intergovernmental Review

This funding opportunity announcement is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

4. Funding Restrictions

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings;
- Basic research (e.g. scientific or medical experiments); and,
- Continuation of existing projects without expansion or new and innovative approaches.

V. APPLICATION REVIEW INFORMATION

Criteria

CMS and AoA Project Officers will use the following review criteria as a guide in determining ranking and approval of grants. Applications will be scored by assigning a maximum of 100 points across four criteria:

A. Current Status of ADRC and MFP-ADRC Partnership - (10 points)

B. Goals, Objectives, and Outcomes – (20 points)

C. Proposed Project and Project Management – (60 points)

D. Budget (10 points)

A. Current Status of ADRC and MFP-ADRC Partnership: Weight: 10 points

i. Does the applicant provide a candid and clear assessment of the current state of ADRC development in the state and existing involvement of ADRCs in the state's MFP program? Does the applicant clearly understand the current role of the ADRC within the MFP program? Are the organizations operating the ADRCs experienced serving the MFP target populations? Do they have meaningful partnerships in place with organizations in their community that will be key to supporting MFP activities, such as CILs, AAAs, hospitals, nursing facilities and institutions? (10 points)

B. Goals, Objectives, and Outcomes: Weight: 20 points

i. Are the expected project benefits/results clear, realistic, and consistent with the objectives and purpose of the project? Are the anticipated outcomes of the proposed project likely to be achieved and will they benefit the populations affected by the intervention? (20 points)

C. Proposed Project and Project Management: Weight: 60 points

i. Is the proposed approach to more effectively involving ADRCs in MFP sound and realistic? Does the applicant clearly identify the new or expanded role/activities of the ADRC(s) in MFP activities and how this project will build on any existing ADRC involvement in MFP activities? Does the proposed approach fully leverage the strengths of the ADRC to support MFP goals and MDS 3.0 Section Q implementation? Is it clear how the proposed approach will advance MFP goals or other diversion and transition goals of the state? Is there a realistic plan to continue some or all project activities after Federal grant funding has ended? (40 points)

ii. Does the applicant clearly delineate of the roles and responsibilities of project staff with the MFP program and those at the participating ADRCs, plus any consultants and partner organizations directly relevant to the project? Is the division of responsibility and accountability conducive to a meaningful partnership between the ADRCs and the MFP program? Does the applicant demonstrate an awareness of potential challenges or barriers to the partnership and do they have a practical plan for working through them? (20 points)

D. Budget: Weight: 10 points

i. Is the budget justified with respect to the adequacy and reasonableness of resources requested? Are budget line items clearly delineated? (10 points)

Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria if applicable. These reviewers are experts in their field. Based on the Application Review Criteria as outlined under section V.1, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Final award decisions will be made by the Administrator of CMS in consultation with the Assistant Secretary for Aging (ASA). In making these decisions, the CMS Administrator will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Applicants will be notified within 30 days of the final funding decision and will receive an approval or disapproval letter via e-mail or U.S. mail.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement located at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm.

VII. AGENCY CONTACTS

Project Officer:
U.S. Department of Health and Human Services
Center of Medicare & Medicaid
7500 Security Blvd.
Baltimore, Maryland 21244-1850
Attn: Sarah Fogler,
E-mail: Sarah.Fogler@CMS.hhs.gov

OMB Approval No. 0985-0018
Expiration 05/31/2010

D. ADRC Evidence-Based Care Transition Programs *(Center For Technology and Aging Funding Opportunity)*

This Program Announcement includes a special funding opportunity being made available by The Center for Technology and Aging, with support from the SCAN Foundation, to support the use of assistive technologies in the Evidence-Based Care Transition Programs funded under this Announcement.

Program Announcement and Grant Application Instructions

U.S. Administration on Aging
FY 2010

Department of Health and Human Services (HHS)
Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services

Announcement Type: Initial
Funding Opportunity Number: HHS-2010-AOA-CT-1026
Catalog of Federal Domestic Assistance (CFDA) Number: 93.048

Key Dates:

Open Information Teleconference:	June 22, 2010, 3:30 EST
Teleconference Number:	1-888-469-1668, pass code: 4536588
Recorded Call-back # (To listen to recorded teleconference)	1-866-873-4963, pass code: 4536588
Voluntary Notice of Intent to Apply:	July 1, 2010
Grant Application Due Date:	July 30, 2010
Issuance of Notice of Grant Awards:	Prior to September 30, 2010
Grant Period Start Date:	September 30, 2010

Funding Summary:

Award Type:	**Cooperative Agreement**
Federal funds available:	**Approximately $2.5 million**
Est. Number of Awards:	**Approximately 6**
Project Start Date:	**Sept 30, 2010**
Eligible Applicants:	**One State Agency or instrumentality of the State from any State that received an AoA or CMS ADRC or Hospital Discharge Planning Grant Award between fiscal years 2003 and 2009 (see the section on Eligibility Information for more details)**
Est. Total Award:	**Approximately $400,000 for 24-month period**
Project Period Length:	**24 months**
Budget Periods Length:	**Two 12-month budget periods**

I. FUNDING OPPORTUNITY DESCRIPTION

1. Statutory Authority

The statutory authority for grants under this Program Announcement is contained in SEC. 2405 of the Patient Protection and Affordable Care Act, and Titles II and IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365. (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects).

2. Background

Re-hospitalization is a "frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care" after an individual is discharged from a hospital.[4] Researchers estimate that one-fifth of Medicare beneficiaries who are discharged from hospitals are readmitted within 30 days, one-third are readmitted within 90 days, and that the national fiscal impact to Medicare as a result of unplanned hospital readmissions was $17.4 billion in 2004.[5] In addition to these costs, re-hospitalization appears to increase the risk of health complications, resulting in greater functional and cognitive impairments for patients.[6]

Reducing the rates of readmission has become a high priority for policymakers and payers seeking to improve health care quality and contain costs. For example, the Medicare Payment Advisory Council (MedPAC) concluded that a large proportion of re-hospitalizations are potentially preventable and recommended improving discharge planning processes. These improvements can include improving communication before and after discharge, as a way to decrease these potentially preventable re-hospitalizations. MedPAC noted that coordinated care after discharge could help improve the quality of care during the initial admission and can prevent re-hospitalization of patients.[7]

Research on care transitions: Research in recent years on care transitions activities (or care coordination programs with care transitions elements) has established a strong evidence base for several types of interventions. A randomized controlled evaluation of the Care Transitions Intervention showed that participants that received the intervention had lower rehospitalization rates at 30 days and at 90 days than control subjects, and the intervention patients had lower mean hospital costs than the control group.[8] A separate randomized evaluation of the Transitional Care Model showed that intervention patients had lower rehospitalization and mean hospital costs than the control participants.[9] Among physician-based care management programs with care transitions elements, a randomized study of the Geriatric Resources for Assessment and Care of Elders (GRACE) Model showed that for participants in a high-risk group, utilization of preventive services increased while the number of hospital admissions declined significantly.[10] Moreover, a randomized study of Guided Care, a nurse-physician care management program, showed fewer hospital and nursing facility days for intervention participants than the control group.[11]

Prior and Ongoing Initiatives: AoA and CMS have funded several initiatives related to improving the coordination of care transitions, and this Program Announcement is intended to build upon the activities of the past several years. Since AoA and CMS first

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[4] Jencks S, Williams M, Coleman E. Re-hospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009;360:1418-28.

[5] Jencks S, Williams M, Coleman E. Re-hospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009;360:1418-28.

[6] Ouslander, J.G., A.D. Weinberg, and V. Philips. Inappropriate Hospitalization of Nursing Facility Residents: A Symptom of a Sick System of Care for Frail Older People. Journal of American Geriatric Society, 48(2). 2000: 154-63.

[7] Medicare Payment Advisory Commission. Report to Congress: Improving Incentives in the Medicare Program. June 2009.

[8] Coleman EA, Parry C, Chalmers S, Min SJ. *The Care Transitions Intervention: Results of a Randomized Controlled Trial.* Archives of Internal Medicine. 2006;166:1822-8.

[9] Naylor, M.D., et al. *Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial*. Journal of the American Geriatric Society, 2004. Volume 52, pp 675-684,.

[10] Counsell SR, Callahan CM, Tu W, Stump TE, Arling GW. *Cost analysis of the Geriatric Resources for Assessment and Care of Elders care management intervention.* J Am Geriatr Soc. 2009 Aug;57(8):1420-6.

[11] Leff B, Reider L, Frick KD, Scharfstein DO, Boyd CM, Frey K, Karm L, Boult C. *Guided Care and the Cost of Complex Healthcare: A Preliminary Report.* Am J Manag Care 2009;15(8):555-559.

began funding ADRC development in 2003, ADRCs have been working to assist individuals in "critical pathways," which is defined as the times or places when people make important decisions about long-term care. This work included several innovative interventions to facilitate the hospital discharge process and to help nursing facility residents return to the community. Since that time, evidence-based models of person-centered care coordination have expanded around the country, and the 2009 AoA program announcement for ADRCs, "Empowering Individuals to Navigate Their Health and Long-Term Support Options," emphasized reaching people during transitions from one care setting to another by naming "person-centered hospital discharge planning" as a key operational component of an ADRC.

Texas provides an excellent example of an ADRC's involvement in care transitions activities and successful partnership with hospital discharge planners:

> The Central Texas ADRC partnered with Scott & White HealthCare to implement the Care Transitions Intervention (www.caretransitions.org). The ADRC and hospital discharge planners work together to identify consumers and their caregivers who are at risk of institutionalization. ADRC Care Transition Specialist**s** are embedded with the Scott & White HealthCare's Department of Continuum of Care (i.e., discharge planning and rehabilitation services) on the main campus of Scott & White HealthCare to coach consumers and their caregivers to ensure that their needs are met in the transition from acute care to a community setting**.** Central Texas ADRC also provides training to staff and other health professionals about the ADRC.

Other recent and ongoing CMS endeavors have focused on hospital discharge planning, including:

- Development of a Consumer Discharge Planning checklist (for use by consumers and their caregivers) and outreach campaign in spring 2008, followed by development of a best practice discharge planning model.
- Quality Improvement Organizations (QIO) Program 9th Statement of Work: QIOs are working with providers in select locations to improve after-hospital care by improving the reliability of high quality care, improve efficiency and value of care, and develop insights and infrastructure.
- Development and testing of a consumer assessment instrument: "Internet-based CARE (Continuity Assessment Record & Evaluation) Patient Assessment Instrument" being tested for use by multiple providers including hospitals.
- Funding Real Choice Systems Change grants in 2008 and 2009 to develop "Person-Centered Hospital Discharge Models." Almost all of these projects are developing their models within the context of ADRC implementation.

3. 2010 Funding Priorities.

Under this Program Announcement, AoA is making funds available for states to significantly strengthen the role of ADRCs in implementing evidence-based care transition models that meaningfully engage older adults and individuals with disabilities (and their informal caregivers). Applicants are limited to states increasing the capacity and/or geographic reach of ADRCs that already are involved in evidence-based care transition

models.

This grant opportunity is designed to promote the further development and enhancement of ADRC participation in evidence-based care transition models. This may include:

- Increasing the capacity of ADRCs' current involvement in evidence-based care transition initiatives by expanding the reach of the ADRC efforts (e.g., adding additional staff, expanding an intervention to serve new populations, or expanding to additional sites).
- Strengthening the extent to which existing transitions programs leverage the assets of the ADRCs (e.g., to streamline access to public benefits, link individuals with community-based services and supports, and counsel individuals and their families on service options) among programs where ADRCs have a limited role currently.
- Informing AoA/CMS, other Federal agencies and Congress on national policy related to care transitions, hospital discharge planning, person-centered planning, and mechanisms to reduce unnecessary hospital re-admissions.

This funding is not intended to support the development of new care transition models, per se, nor is it meant to build new relationships where none already exist. Rather, we are focusing on strengthening and expanding activities that are already well-developed and already have the active involvement of key partners.

This Program Announcement includes a special funding opportunity being made availability by The Center for Technology and Aging, with support from the SCAN Foundation, to support the use of assistive technologies in the Evidence-Based Care Transition Programs funded under this Announcement. For instructions on how to apply for this opportunity, see ***Attachment L****.*

Evidence-Based Care Transition Programs That Are Fundable Under this Announcement.

Funding under this Announcement is only available to support ADRC involvement with *evidence-based* care transition models. In the following paragraphs, we describe four models that meet AoA standards for this program announcement: two prominent hospital-based care transitions models and two prominent physician/practice based care transitions models. These are evidence-based models that applicants should consider. However, applicants may propose other evidence-based care transition models. Applicants proposing to employ models other than the four described below must cite and summarize the research findings, and the model must be based on one or more randomized controlled trials that demonstrate how the model reduces hospital readmissions and improves participant quality of life. The model must also allow for a meaningful role for community-based organizations such as ADRCs. All applicants must describe the rationale for their choice of models.

The Care Transitions Intervention (CTI) is a four-week hospital-to-home care transitions model during which patients with complex care needs and family caregivers receive specific tools and work with a "Transitions Coach" to learn self

management skills that will ensure their needs are met during the transition from hospital to home.

During the hospital visit, home visit and three follow up phone calls, the coach focuses on the following:

- Providing continuity of care across settings, and supporting the patient in developing and maintaining a personal health record.
- Helping the patient and family members to understand when and how to obtain timely follow-up care (including both primary and specialty care).
- Coaching/role playing with patients to ask the right questions to the right health care providers to get their needs met across the various follow-up care settings.
- Helping patients and their families to play a more active role in managing their condition and to develop self-care skills, including medication self-management and increased awareness of symptoms, and recognizing "red flags," and warning signs that trigger the need for care, along with instructions on how to respond to them.

The program has been tested for community dwelling adults that are 65 years or older with at least one of 11 diagnoses. A randomized study of the program showed that the program cost was $74,310 for 379 patients ($196/patient) and another study reported that intervention patients saw an estimated annual cost savings, over and above the cost of the intervention, of $844 per patient.[12,13]

The Transitional Care Model (TCM) provides comprehensive discharge planning and home follow-up by advanced practice nurses (APNs) to older adults at high risk for poor outcomes. The following are core elements of the TCM:

- In-hospital assessment (including detailed assessment of each patients' functional status), collaboration with team members to reduce adverse events and prevent functional decline, and preparation and development of a streamlined, evidenced-based plan of care.
- Regular home visits by the APN with available, ongoing telephone support (seven days per week) through an average of two months post-discharge.
- Continuity of medical care between hospital and primary care providers facilitated by the APN accompanying patients to first follow-up visit(s).
- Comprehensive, holistic focus on each patient's goals and needs including the reason for the primary hospitalization as well as other complicating or coexisting health problems and risks.
- Active engagement of patients and family caregivers with focus on meeting their goals.
- Emphasis on patients' early identification and response to health care risks and symptoms to achieve longer term positive outcomes and avoid adverse and untoward events that lead to readmissions.

[12] Coleman EA, Parry C, Chalmers S, Min SJ. The Care Transitions Intervention: Results of a Randomized Controlled Trial Archives of Internal Medicine. 2006;166:1822-8.

[13] Coleman EA. Encouraging Patients and Family Caregivers to Assert a More Active Role During Care Hand-Offs: The Care Transitions Intervention. Last accessed April 30, 2010 at: http://www.caretransitions.org/documents/Evidence_and_Adoptions.pdf

- Multidisciplinary approach that includes the patient, family caregivers and health care providers as members of a team.
- Physician-nurse collaboration across episodes of acute care; and
- Communication to, between, and among the patient, family caregivers, and health care providers.

The program has been tested with patients that are 65 years or older with poor self-health ratings, multiple chronic conditions and a history of recent hospitalizations. One randomized study of the program indicated that the annual total intervention cost was $115,856 ($982 per patient). The study also concluded that reductions in utilization of health services led to mean annual cost savings, over and above the costs of the intervention, of $5,000 per patient.[14]

Guided Care is a physician/nurse care coordination model, usually conducted for a long-term/indefinite amount of time. The role requires a Guided Care Nurse to:

- Conduct a comprehensive home assessment
- Create an evidence-based care guide for the patient and a patient-friendly action plan for the patient
- Provide monthly monitoring and self-management coaching
- Smooth transitions into and out of hospitals and other institutions
- Coordinate care by all providers
- Provide family caregiver education/support, and
- Facilitate access to community based services.

The program is being tested for individuals age 65 years or older who are at high risk of utilizing health services heavily during the following year. Preliminary results from a randomized evaluation of the program indicate that the total annual intervention cost was $1,743 per patient, producing a savings, above and beyond the cost of the intervention, of $1,364 per patient.[15]

Recipients of Guided Care were twice as likely to rate the quality of their health care in the highest category, while their family caregivers felt less strain and their physicians were more satisfied.[16,17, 18]

Geriatric Resources for Assessment and Care of Elders (GRACE) is a physician/practice-based care coordination model, conducted for a long-term/indefinite amount of time that requires a nurse practitioner and social worker to:

[14] Naylor, M.D., et al. Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. Journal of the American Geriatric Society, 2004. Volume 52, pp 675-684,.

[15] Leff B, Reider L, Frick KD, Scharfstein DO, Boyd CM, Frey K, Karm L, Boult C. Guided Care and the Cost of Complex Healthcare: A Preliminary Report. Am J Manag Care 2009;15(8):555-559.

[16] Boyd CM et al. The Effects of Guided Care on the Perceived Quality of Health Care for Multi-morbid Older Persons: 18-Month Outcomes from a Cluster-Randomized Controlled Trial. J Gen Intern Med 2010; 25(3):235-242.

[17] Wolff JL et al. Caregiving and Chronic Care: The Guided Care Program for Families and Friends. Journal of Gerontol Med Sci 2009;64A(7):785-791. Wolff JL et al. Effects of Guided Care on Family Caregivers. Gerontologist 2009 Epub Aug 26.

[18] Marsteller J et al. Physician Satisfaction with Chronic Care Processes: a Cluster-Randomized Trial of Guided Care. Ann Fam Med 2010 (in press)

- Offer in-home assessment and care management
- Collaborate with and support the primary care physician
- Meet with the patient's primary care physician to review, modify and prioritize the care plan, then collaborate with the physician in putting it into practice
- Work weekly with geriatrician-led interdisciplinary team to craft patient care plan
- At least one in-home follow-up visit to review the care plan, and one telephone or face-to-face contact per month
- Coordinate care from all providers, and
- Collaborate with hospital discharge planners, and make a home visit after any hospitalization.

GRACE has been tested for low-income individuals age 65 years or older in primary care, including a group at high risk of hospitalization as determined by the probability of repeated admission risk screen. A randomized study indicated the total annual intervention costs for high-risk patients to be $315,040 ($1,432 per patient). The study concluded the intervention to be cost-neutral for high-risk patients due to reductions in hospital costs.[19]

Role of ADRCs in Evidence-Based Models: For this program announcement, all applicants must – before submitting an application – have established partnerships with one or more hospitals, clinics, or physician practices related to the implementation of evidence-based care transitions activities. Because ADRCs have different funding, capacity, and partners, ADRCs might serve different roles within these partnerships. For this solicitation, applicants must clearly describe the role that ADRCs will play in the care transitions activities. Roles for ADRCs include:

- **Providing staffing for care transitions activities:** In partnership with other key partners, ADRCs can hire and directly manage care transitions workers. The type of staff will differ for each evidence-based model. For example:
  - ***Northeast Georgia ADRC*** currently provides "transition coaching" for hospital patients to encourage or assist with physician appointments after discharge, ensure that community services are in place, provide options counseling, and promote use a patient health record.
  - ***Ohio's 10B AAA*** is implementing the Care Transitions Intervention (CTI) as a complement to their efforts to help hospital patients enroll in the appropriate Medicaid waiver programs.

- **Funding care transitions staff at other organizations:** Rather than hire a care transitions worker on staff, ADRCs can contract with other organizations to partially or completely cover the costs of the additional staff. This role may be appropriate at sites where the hiring process is problematically slow. It may also help cultivate deeper buy-in from partners and better access to provider data systems. For example:

[19] Counsell SR, Callahan CM, Clark DO, Tu W, Buttar AB, Stump TE, Ricketts GD. Geriatric care management for low-income seniors: a randomized controlled trial. JAMA, 2007. 298(22), 2623-2633.

- ***Central Texas ADRC*** funds a CTI transitions coach that works at Scott & White Healthcare with the hospital as the employer of record. This transitions coach refers patients to the ADRC's more intensive REACH-II intervention if appropriate.
- ***Many ADRC operating organizations and partners (e.g. CILs)*** have community "re-integration" coordinators established and working on transitions from hospitals or nursing homes back into the community.

- **Actively collaborating with existing care transitions project:** Where ADRCs do not provide staffing or funding for care transitions staff, they can still support care transitions through active involvement on interdisciplinary care teams or other activities. This type of role may work best in communities where there are strong care transitions initiatives that could benefit from increased involvement from ADRCs. For example:
  - **Indiana's ADRCs** participate in the GRACE Intervention as partners – primarily providing connections to community based services as participants on interdisciplinary teams.

Funds May be Used To:
Funds may be used to assist states in enhancing ADRC roles in care transition initiatives (which may include hiring new staff to focus on transitions) and/or to expand care transition model into new geographic area. The award may be used to cover:

1. Staffing-related costs necessary to expand or enhance care transitions activities, including:
   - Staff time for:
     - Direct contact with patients and their families (e.g., in-hospital visits, in-home follow-up, telephonic contacts, etc), as dictated by the type of intervention
     - Outreach and collaboration with hospital staff and community partners
     - Documentation, data collection, and reporting
     - Training
   - Related costs for:
     - Transportation (e.g., staff transportation for home visits)
     - Office space and supplies
2. Direct costs for training ADRC staff or staff from other partners on the intervention (note that some evidence-based models call for specific training requirements)
3. Costs related to health information technology necessary to implement the chosen evidence-based model (e.g., access to electronic health records or other data systems)
4. Data collection and evaluation
   - Satisfaction surveys
   - Focus groups
   - Independent evaluations
5. Incidental costs related to the initiative
   - Travel to national conference, etc

Key Deliverables

1. Active participation with other grantees to develop consistent data collection processes and outcome measures, share lessons learned, support the development of care transitions activities at new sites across the country and define a core set of expectations for how ADRCs should be involved in/support care transitions activities

2. Develop and implement a formal evaluation to assess fidelity to the evidence-based model, document changes in hospital re-admission rates, and monitor other outcomes including providing:

- Evidence that the health and well being of individuals transitioning from different care settings has improved
- Evidence that rates of hospital re-admissions have declined
- Documentation of efficiency and/or cost savings by the end of project

3. Final report that summarizes lessons learned, documents the number of people assisted during the project, and provides recommendations for how ADRCs may support evidence-based care transition and care coordination activities nationwide

Partnerships

Applications submitted for the care transitions component under this Program Announcement must demonstrate strong *existing* relationships between the organizations involved in the care transitions activities. The ADRC must already have a written agreement in place with the primary service providers (e.g., hospitals, clinics, physician practices) that will be part of this initiative. All applications must include substantive roles for the Aging and Disability Resource Center(s) that serves the geographic area in which the care transitions activities will occur. For hospital-based projects, the applicant must also partner with the State's Quality Improvement Organization. At the state level, the State Unit on Aging, State Medicaid Agency, and State Disability Agency (where applicable) must be involved in program planning, development, implementation, and evaluation.

Other partnerships will depend on the nature of the initiative, but may include advocacy organizations, provider associations, and any state or local agencies involved in project implementation. We strongly encourage that applicants build on and collaborate with the 2008 and 2009 Real Choice Systems Change Hospital Discharge Planning grantees to strengthen and coordinate services within the State to allow streamlined access to long-term services and supports. Applicants should also highlight roles for consumers, their families, and other key stakeholders affected by the initiative.

Required Partners	Suggested Partners
• ADRC* • Service providers directly involved in the initiative* • Quality Improvement Organizations** • State Unit on Aging • State Medicaid Agency • State Disability Agency (where applicable)	• Advocacy organizations • Provider associations • Professional associations (e.g., discharge planners)

*Must have written agreement and or evidence that an existing relationship is in place at the time of the application.
** QIO partnerships are only required for hospital-based projects but recommended for all applicants.

Applicants will be expected to meet the following key deadlines:

Activity/Deliverable	Deadline
Active participation to develop consistent data collection and outcome measures	During first three months after award and continuing through the duration of the initiative
Evaluation plan that outlines how grantee will measure outcomes and provide: o Evidence that the health and well being of individuals transitioning from different care settings has improved o Evidence that rates of hospital re-admissions have declined o Documentation of efficiency and/or cost savings by the end of project	Due to AoA three months after award
Semi-Annual Reports to include: o Information about grant activities, progress, challenges and lessons learned o Number of people served through the initiative and other measures to be determined with grantee input and participation	Due to AoA every six months as part of regular ADRC Semi-Annual Reporting process
Final Report, including lessons learned and evaluation findings	Due to AoA three months after grant period ends

II. AWARD INFORMATION

Award Type:	**Cooperative Agreement**
Federal funds available:	**Approximately $2.5 million**
Est. Number of Awards:	**Approximately 6**
Project Start Date:	**Sept 30, 2010**
Eligible Applicants:	**One State Agency or instrumentality of the State from any State that received an AoA or CMS ADRC or Hospital Discharge Planning Grant Award between fiscal years 2003 and 2009 (see the section on Eligibility Information for more details)**
Est. Total Award:	**Approximately $400,000 for 24-month period**
Project Period Length:	**24 months**
Budget Periods Length:	**Two 12-month budget periods**

Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. AoA reserves the right to offer a funding level that differs from the requested amount, including amounts less than the amount the applicant has requested. AoA reserves the right to defer applications for consideration in future fiscal years, as funds may not be available to support all proposals.

These grants will be issued as Cooperative Agreements because AoA, in collaboration with CMS, anticipates having substantial involvement with the recipients during performance of funded activities. For additional information on the level of AoA's and grantee involvement as outlined in the Cooperative Agreement please see **Attachment K**. Grantees will be expected to maintain regular contact with their federal project officer and to cooperate with the AoA and CMS Technical Assistance Centers. Grantees will also be expected to share all significant products and activities with AoA and CMS.

Once a cooperative agreement is in place, requests to modify or amend it or the work plan may be made by AoA or the awardee at any time. Modifications and/or amendments of the Cooperative Agreement or work plan shall be effective upon the mutual agreement of both parties, except where AoA is authorized under the Terms and Conditions of award, 45 CFR Part 74 or 92, or other applicable regulations or statutes to make unilateral amendments.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Only a state agency or instrument of a state from a State that: 1) received an award to implement ADRCs through the AoA and CMS ADRC grants funded in fiscal years 2003, 2004, 2005 and 2009, and/or the CMS Person-Centered Hospital Discharge Planning Model Grants funded in fiscal years 2008 and 2009 may apply for this funding opportunity; and 2) continues to implement and operate the ADRC activities funded through their grant award(s), may apply for this funding

opportunity. **AoA will accept only one application per state**. The applicant agency must have the support and active participation of the State Unit on Aging, the Single State Medicaid Agency, and State Disability Agencies where applicable. "State" refers to the definition provided under 45 CFR 74.2.

Executive Order 12372 is not applicable to these grant applications.

2. Cost Sharing or Matching

Matching funds are not required. Please disregard any reference to "AoA Required Match" found in the Attachments.

Please note, applications that include any form of match will **not** receive additional consideration under the review. Match is not one of the responsiveness criteria as noted in Section III, 3 Application Screening Criteria.

3. Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the screening criteria described below will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

A. Applications must be submitted electronically via http://www.grants.gov by 11:59 p.m., Eastern Time, July 30, 2010.

B. The Project Narrative section of the Application must be **double-spaced**, on 8 ½" x 11" plain white paper with **1" margins** on both sides, and a **font size of not less than 11**.

C. **The Project Narrative must not exceed 10 pages**. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel **are not counted** as part of the Project Narrative for purposes of the 10-page limit.

4. Application Responsiveness Criteria

Again, to assure a level playing field for all applicants, applications that fail to meet the following responsiveness criteria will **not** be reviewed and will receive **no** further consideration:

A. Applicant is a State Agency or instrumentality of the State (e.g., State Unit on Aging, State Medicaid Agency, State Disability Agencies);

B. Applicant has received an award to implement ADRCs through the AoA and CMS ADRC grants funded in fiscal years 2003, 2004, 2005 and 2009,

and/or the CMS Person-Centered Hospital Discharge Planning Model Grants;

C. Applicant has identified/proposed an evidenced-based care transition intervention as part of their proposed project; and

D. Applicant has submitted a written agreement or letter of commitment from one or more hospitals, clinics, or physician practices related to the implementation of evidence-based care transitions activities.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx.

Contact person regarding this Program Announcement:

U.S. Department of Health and Human Services
Administration on Aging
Kevin Foley
Office of Planning and Policy Development
Washington, D.C. 20201
E-mail: Kevin.Foley@aoa.hhs.gov

Please note, AoA is requiring applications for all announcements to be submitted electronically through http://www.grants.gov. The Grants.gov (http://www.grants.gov) registration process can take several days. If your organization is not currently registered with http://www.grants.gov, please begin this process immediately. **For assistance with http://www.grants.gov, please contact them at** support@grants.gov **or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website (http://www.grants.gov).

Applications submitted via http://www.grants.gov:

- You may access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (HHS-2010-AOA-CT-1026) or CFDA number (93.048).
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. AoA strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal

Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.

- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the http://www.grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- **Your application must comply with any page limitation requirements described in this Program Announcement.**
- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.gov that contains http://www.grants.gov tracking number. The Administration on Aging will retrieve your application form from http://www.grants.gov.
- After the Administration on Aging retrieves your application form from http://www.grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://www.grants.gov.
- Each year organizations registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (http://www.ccr.gov).

2. Content and Form of Application Submission

A. Letter of Intent

To apply for this funding opportunity, AoA strongly recommends that applicants submit a "letter of intent" via email or voice mail to assist AoA in planning for the application independent review process. The deadline for submission of the "letter" is July 1, 2010.

U.S. Department of Health and Human Services
Administration on Aging
Kevin Foley
Office of Planning and Policy Development
Washington, D.C. 20201
e-mail: Kevin.Foley@aoa.hhs.gov

B. DUNS Number

The Office of Management and Budget requires applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements on or after October 1, 2003. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.

Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf .

C. Project Narrative

If applicants choose to use another format for their Project Narrative, it must be double-spaced on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. AoA will not accept applications with a Project Narrative that exceeds 10 pages. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. The Project Work Plan, Letters of Commitment, and Vitae of Key Personnel are not counted as part of the Project Narrative for purposes of the 10-page limit, but all of the other sections noted below are included in the limit.

The components counted as part of the page limit include:

1. Summary/Abstract

2. Current Activities and Proposed Approach

    a. Current Care Transition Activities
    b. Program Goals
    c. Target Populations
    d. Geographic Coverage
    e. Partnerships
    f. Staff Requirements
    g. System Requirements
    h. Continuous Quality Improvement and Evaluation

3. Organizational Capacity
4. Project Management and Stakeholder Participation

The Project Narrative should provide a **clear and concise** description of your project and it is the most important part of the application because it will be used as the primary basis to determine whether or not your project meets the review criteria. AoA recommends that your project narrative include the following components:

1. Summary/Abstract. This section should include a brief - no more than 265 words maximum - description of the proposed project, including: the goal(s) and objectives, description of the intervention currently in place and how the applicant will use this funding to expand or enhance that intervention.

2. Current Activities and Proposed Approach. Successful applicants will offer a candid assessment of their current involvement in care transitions and describe how they will use this grant opportunity to strengthen or expand their program. Applicants should address each of the following eight components in this section,

using the questions posed in each section to guide and focus their narrative.

a. Current Care Transitions Activities.

- Identify the evidence-based model with which your ADRC is already involved, where it operates, and the specific role of the ADRCs and other partners in care transition activities.
- Briefly describe the accomplishments to date of your care transitions activities, such as numbers of transition coordinators trained and numbers of people served.

b. Program Goals.

- What are your primary goals for this project?
- Which challenges in your current care transitions program do you wish to address with this grant?
- Which areas of success in your current care transitions program do you wish to strengthen with this grant?
- If you propose to change models or implement a model that is not listed in this Program Announcement, describe the evidence base for the model you will use.
- What are your expected outcomes?
- What major barriers to your approach do you anticipate and how will your project be able to overcome those barriers?

c. Target Populations.

- How are consumers who need care transitions services currently identified and referred for this service?
- Which consumer groups and populations currently have access to care transition supports through ADRCs or some other program? Please specify populations in terms of:
  - age and type of disability (e.g. adults with physical/intellectual/ developmental disabilities)
  - income level (e.g. private paying)
  - setting or circumstance (e.g. individuals discharging from a hospital)
- Through this grant, will you expand the model into new settings or serve new target populations?

d. Geographic Coverage.

- Describe the geographic location for your current involvement in care transitions activities.
- Describe whether and how your ADRC care transitions activities will be expanded into new regions in the state.

e. Partnership Requirements.

- Briefly assess your current partnerships and how you propose to strengthen them through this project?
- How will you resolve conflicts or challenges that arise among partners over the course of the project?

f. Staff Requirements.

- For each of the following areas, describe your current staffing standards (especially for care transitions coordinators) and any ways in which these will change under the new activities.
    - Credentials
    - Training
    - Numbers Served and Consumer to Staff (Case Load) Ratios
- Overall, how will you ensure that transition coordinators are prepared to serve the ADRC's different target populations in the proposed settings and circumstances?

g. System Requirements

- Administrative and Management
    - What standards, tools, resources, or protocols are currently used to guide and support care transitions (shared health record, medication management tools, etc.)
    - What tools or protocols will be developed to better manage the care transitions program?
- Data and Information Systems
    - What IT/MIS developments or enhancements will be necessary to track care transitions services and consumer outcomes over time?

h. Continuous Quality Improvement and Evaluation.

- How will you evaluate the impact of your enhanced program?
- What data elements related to care transitions do ADRC staff currently collect and track at the programmatic level?
- What indicators and measures do you propose to track under the new standards and how do they relate to the future sustainability of the project?
- To what extent will you have access to data from partnering organizations such as hospitals?
- What type of tools and processes will be employed to continuously monitor and improve service delivery?

3. Organizational Capacity. Applicant should describe the capacity of the ADRCs that will have an operational role in performing the care transitions functions. Clearly and concisely describe the length of time that the participating ADRCs have been operating in the state, the populations they serve, the types of agencies operating the ADRCs (e.g., AAAs, Centers for Independent Living), and their core functions. Describe how you would maintain the initiative if a key staff person (such as program managers and care transition coordinators) leaves his/her

position during the course of the project. Applicants should include an organizational capability statement, organizational charts, and vitae for key project personnel. Neither vitae nor an organizational chart will count towards the narrative page limit.

4. Project Management. Applicants should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. It should specify who will have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports; communications with partner agencies and key stakeholders, and AoA. Describe qualifications and training for the staff directly implementing the intervention.

D. Work Plan:

Applicants should provide a realistic timetable and work plan that outlines the extent to which they will be able to complete each activity within the 24-month project period as well as a description of how each activity will contribute to the overall goals and objectives of the program and to the system changes described in this Announcement.

The Project Work Plan should reflect and be consistent with the Project Narrative and Budget and should cover all 24 months of the project period. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks / action steps that will be pursued to achieve the goal and outcome(s). For each major task / action step, the work plan should identify the timeframes involved (including start- and end-dates), and the lead person responsible for completing the task. Please use the Sample Work Plan format included in the Attachments.

E. Letters of Commitment and other Written Agreements from Key Participating Organizations and Agencies:

Applicants must submit a copy of the existing written agreements they have in place between the participating ADRC(s) and service provider(s) to demonstrate the ADRC's current involvement in care transitions activities. The written agreement must indicate that the parties are currently collaborating on an evidence-based care transitions program. If the written agreement does not already encompass the activities proposed in this application, the applicant should also include letters of commitment from the service provider(s) specific to the new activities proposed.

Applicants proposing to expand their activities to new sites must submit written agreements or letters of commitment from the new hospitals and/or other partnering providers who will participate in this project. These documents will be an important mechanism for demonstrating commitment from the service provider(s).

Applicants should also include confirmation of the commitments to the project made by key collaborating organizations and agencies. This should include at a

minimum letters of commitment from 1) the participating ADRC(s) and 2) the directors of: the State Unit on Aging, the State Medicaid Agency, and State Disabilities Agencies where applicable. For applications submitted electronically via http://www.grants.gov, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the AoA Office of Grants Management at 202-357-3466 no later than the application submission deadline.

F. Budget Narrative/Justification:

The Budget Narrative/Justification should be provided using the format included as an attachment of this Program Announcement. **Applicants are encouraged to pay particular attention to Attachment B, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required.** Applicants should also ensure that funds are delineated for two representatives to attend one national meeting/event during each of the two years of the overall project period. This national meeting may be specific to the care transitions component of this Program Announcement (i.e., in addition to other national ADRC meetings).

3. Submission Dates and Times

Applicants are requested, but not required, to submit a letter of intent to apply for this funding opportunity. The letter of intent assists AoA in planning for the independent review process of the applications. The deadline for submission of letters of intent is July 1, 2010.

The deadline for the submission of completed applications under this program announcement is July 30, 2010. Applications must be submitted electronically at http://www.grants.gov by 11:59 p.m. Eastern Time, July 30, 2010. Applications that fail to meet the application due date will **not** be reviewed and will receive **no** further consideration.

Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in Grants.gov. After the Administration on Aging retrieves your application form from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

An open information teleconference for applicants of this solicitation will be held June 22, 2010 at 3:30 p.m., EST. The toll-free teleconference phone number will be 888-469-1668, pass code: 4536588.

4. Intergovernmental Review

This funding opportunity announcement is not subject to the requirements of Executive Order 12372, “Intergovernmental Review of Federal Programs.”

5. Funding Restrictions

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings;
- Basic research (e.g. scientific or medical experiments); and,
- Continuation of existing projects without expansion or new and innovative approaches.

V. APPLICATION REVIEW INFORMATION

Criteria

Applications are scored by assigning a maximum of 100 points across four criteria:

A. Current Activities and Proposed Approach- (50 points)

B. Project Management - (20 points)

C. Organizational Capacity - (20 points)

D. Work Plan and Budget – (10 points)

A. Current Activities and Proposed Approach Weight: 50 points

i. Does the applicant demonstrate a clear understanding of the goal of this Program Announcement and its relevance to their state and community needs? Does the application adequately describe the current status of their ADRC care transitions program and how it will be strengthened, expanded or improved through this grant? Does the ADRC demonstrate strong existing relationships and commitment from hospital partners (or other provider organizations as appropriate) for the care transitions program? Does the ADRC adequately describe the strengths and weaknesses of their care transitions program that might be addressed by this project? (20 points)

ii. Does the applicant articulate a coherent plan to strengthen the successful components of their current program, address identified problems, and achieve identified outcomes? Are the expected benefits/results clear, realistic, and consistent with the objectives and purpose of the project? Does the applicant make a strong case that strengthening and/or expanding their care transitions program in the way they propose will benefit the community? Do they offer adequate explanation for expanding care transition services into new settings or into new target populations as they propose? Does the applicant adequately describe the evidence base for the care transitions intervention they propose to use (if it is not a model listed in the Program Announcement)? (20 points)

iii. Does the applicant clearly outline how services delivered will be tracked and

how the impact of the program will be evaluated? Will they capture information about their experience that will benefit other ADRCs and care transitions programs? Do they demonstrate their capacity to produce, at a minimum, evidence that the health and well being of individuals transitioning from different care settings has improved, evidence that rates of hospital re-admissions have declined, and documentation of any efficiency and/or cost savings by the end of project? (10 points)

B. Project Management **Weight: 20 points**

i. Does the proposal include a clear and coherent plan for managing the project and ensuring that key activities are accomplished and key deliverables are produced in the necessary time frames? Are the roles and responsibilities of project staff, consultants and partners clearly defined and linked to specific objectives and tasks? Does the applicant demonstrate an awareness of potential conflicts, challenges or barriers to the project, particularly those related to partnership and staff turnover, and explain what approach they would use to resolving them? (20 points)

C. Organizational Capacity **Weight: 20 points**

i. Do the proposed project director(s), key staff and consultants have the background, experience, and other qualifications required to carry out their designated roles? Do the organizations who will implement the new care transitions activities have the experience and capacity necessary to implement and evaluate the activities within the timeframe of this grant project? (10 points)

ii. Are written agreements with provider partners and letters from participating organizations included, as appropriate? Are they clear and specific about the roles of the ADRC? Do they demonstrate clear buy-in to the project? (10 points)

D. Work Plan and Budget **Weight: 10 points**

i. Does the work plan include sensible and feasible timeframes for the accomplishment of tasks presented? Does the work plan include specific objectives and tasks that are linked to measurable outcomes? (5 points)

ii. Are budget line items clearly delineated and consistent with work plan objectives? Is the budget justified with respect to the adequacy and reasonableness of resources requested? Is the time commitment of the proposed director and other key project personnel sufficient to assure proper direction, management and meaningful engagement in the project? (5 points)

Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria if applicable. These reviewers are experts in their field, and are drawn from academic institutions, non-profit organizations, state and local government, and Federal government agencies. Based on the Application Review Criteria as outlined under section V.1, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration on Aging authorizing official, Officer of Grants Management, and the AoA Office of Budget and Finance. Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement located at http://www.hhs.gov/grantsnet/adminis/gpd/index.htm.

3. Reporting

The SF-269 (Financial Status Report) is due annually and the AoA program progress report is due semi-annually. Final performance and SF-269 reports are due 90 days after the end of the project period. For more information on this process, please see **Attachment M** of this solicitation on Measurable Performance Goals.

Instructions for annual financial and semi-annual program performance reports will be included with the award packets sent to successful applicants. An original and two copies of the financial report and the AoA program progress report are requested. Awardees will receive instructions for both reports with their Notice of Financial Assistance Award. Final performance and financial reports are due 90 days after the end of the project period. For more information see DHHS / AoA Standard Terms and Conditions.

Grantees are required to submit a quarterly Federal Cash Transaction Report (SF-272) to the Payment Managements System as identified in their award documents for the calendar quarters ending 3/31, 6/30, 9/30, and 12/31 through the life of their award. In addition, a Financial Status Report (SF-269) will be required as denoted in the Notice of Award. Please Note: HHS is transitioning to the combined Federal Financial Report (FFR) known as the SF-425, which will replace the Financial Status SF-269 and Federal Cash Transaction Report SF-272. HHS/AOA will provide further guidance implementing the use of the new form at a later date.

VII. AGENCY CONTACTS

Project Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Kevin Foley
E-mail: Kevin.Foley@aoa.hhs.gov

Grants Management Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Margaret Tolson
E-mail: grants.office@aoa.hhs.gov

VIII. OTHER INFORMATION

Application Elements

SF 424 – Application for Federal Assistance (See Attachment A for Instructions).

SF 424A – Budget Information. (See Attachment A for Instructions).

Separate Budget Narrative/Justification (See Attachments B and C for a Budget Narrative/Justification Sample Format with Examples and a Sample Template).

NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding.

SF 424B – Assurances. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

Lobbying Certification

Proof of non-profit status, if applicable

Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

Project Narrative with Work Plan (See Attachment D for Sample Work Plan Format).

Organizational Capability Statement and Vitae for Key Project Personnel.

Letters of Commitment from Key Partners.

The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The project description and Budget Narrative/Justification is approved under OMB control number 0985-0018 which expires on 5/31/10.

Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

ATTACHMENTS

Attachment A:
Instructions for Completing Required Forms
(SF 424, Budget (SF 424A), Budget Narrative/Justification)

Attachment B:
Budget Narrative/Justification Format – Sample Format with Examples

Attachment C:
Budget Narrative/Justification – Sample Template

Attachment D:
Project Work Plan - Sample Template

Attachment E:
Instructions for Completing the Summary/Abstract

Attachment F:
MIPPA Application Cover Sheet

Attachment G:
MIPPA Funding Allocation By State

Attachment H:
Options Counseling Cooperative Agreement

Attachment I:
Money Follows the Person Awardees (2007)

Attachment J:
Evidence-Based Care Transition Models

Attachment K:
Evidence-Based Care Transition Cooperative Agreement

Attachment L:
Center for Technology and Aging Funding Opportunity

Attachment M:
Voluntary Semi-Annual Reporting Process for ADRC

Attachment N:
Definitions

Attachment A: Instructions for Completing Required Forms
(SF 424, Budget (SF 424A), Budget Narrative/Justification)

This section provides step-by-step instructions for completing the four (4) standard Federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of Federal grant programs, and Federal agencies have the discretion to require some or all of the information on these forms. AoA does not require all the information on these Standard Forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF 424 and 424A to complete these forms.

a. Standard Form 424

1. **Type of Submission:** (Required): Select one type of submission in accordance with agency instructions.
- Preapplication
- Application
- Changed/Corrected Application – If AoA requests, check if this submission is to change or correct a previously submitted application.

2. **Type of Application**: (Required) Select one type of application in accordance with agency instructions.
- New
- Continuation
- Revision

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier**: Leave this field blank

5a **Federal Entity Identifier**: Leave this field blank

5b. **Federal Award Identifier**: For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned Federal award (grant) number.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information**: Enter the following in accordance with agency instructions:

a. Legal Name: (Required): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website (http://www.grants.gov).

b. Employer/Taxpayer Number (EIN/TIN): (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

c. Organizational DUNS: (Required) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website (http://www.grants.gov).

d. Address: (Required) Enter the complete address including the county.

e. Organizational Unit: Enter the name of the primary organizational unit (and department or division, if applicable**)** that will undertake the project.

f. Name and contact information of person to be contacted on matters involving this application: Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application.

9. **Type of Applicant:** (Required) Select the applicant organization "type" from the following drop down list.
A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)

10. **Name Of Federal Agency**: (Required) Enter U.S. Administration on Aging

11. **Catalog Of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of the Program Announcement.

12. **Funding Opportunity Number/Title:** (Required) The Funding Opportunity Number and title of the opportunity can be found on page one of the Program Announcement.

13. **Competition Identification Number/Title:** Leave this field blank.

14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state etc).

15. **Descriptive Title of Applicant's Project:** (Required) Enter a brief descriptive title of the project.

16. **Congressional Districts Of**: (Required) 16a. Enter the applicant's Congressional District, and 16b. Enter all district(s) affected by the program or project. Enter in the

format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina's 103rd district. If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. If nationwide, i.e. all districts within all states are affected, enter US-all.

17. **Proposed Project Start and End Dates**: (Required) Enter the proposed start date and final end date of the project. Therefore, if you are applying for a multi-year grant, such as a 3 year grant project, the final project end date will be 3 years after the proposed start date. In general, all start dates on the SF424 should be the 1st of the month and the end date of the last day of the month of the final year. The Grants Officer can alter the start and end date at their discretion.

18. **Estimated Funding:** (Required) Enter the amount requested or to be contributed during the first funding/budget period by each contributor. If a multi-year application insert the total amount requested over the entire period. Value of in-kind contributions should be included on appropriate lines, as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses.

NOTE: Applicants should review cost sharing or matching principles contained in Subpart C of 45 CFR Part 74 or 45 CFR Part 92 before completing Item 18 and the Budget Information Sections A, B and C noted below.

All budget information entered under item 18 should cover the upcoming budget period. For sub-item 18a, enter the Federal funds being requested. Sub-items 18b-18e is considered matching funds. The dollar amounts entered in sub-items 18b-18f must total at least 1/3rd of the amount of Federal funds being requested (the amount in 18a). For a full explanation of AoA's match requirements, see the information in the box below. For sub-item 18f, enter only the amount, if any, which is going to be used as part of the required match.

There are two types of match: 1) non-Federal cash and 2) non-Federal in-kind. In general, costs borne by the applicant and cash contributions of any and all third parties involved in the project, including sub-grantees, contractors and consultants, are considered **matching funds**. Generally, most contributions from sub-contractors or sub-grantees (third parties) will be non-Federal in-kind matching funds. Volunteered time and use of facilities to hold meetings or conduct project activities may be considered in-kind (third party) donations. Examples of **non-Federal cash match** includes budgetary funds provided from the applicant agency's budget for costs associated with the project.

> NOTE: **Indirect charges** may only be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency; or (2) the applicant is a state or local government agency. State governments should enter the amount of indirect costs determined in accordance with DHHS requirements. **If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application. Further, if any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be**

included with the application.

AOA's Match Requirement

Under this and other OAA programs, AoA will fund no more than 75 % of the **project's total cost**, which means the applicant must cover at least 25% of the **project's total cost** with non-Federal resources. In other words, for every three (3) dollars received in Federal funding, the applicant must contribute at least one (1) dollar in non-Federal resources toward the project's total cost (i.e., the amount on line 18g.). This "three-to-one" ratio is reflected in the following formula which you can use to calculate your minimum required match:

Federal Funds Requested (i.e., amount on line 15a) / 3 = Minimum Match Requirement

For example, if you request $100,000 in Federal funds, then your **minimum** match requirement is $100,000/3 or $33,333. In this example the **project's total cost** would be $133,333.

A **common error** applicants make is to match 25% of the Federal share, rather than 25% of the project's total cost, so be sure to use one of the formulas above to calculate your match requirement.

If the required non-Federal share is not met by a funded project, AoA will disallow any unmatched Federal dollars.

19. **Is Application Subject to Review by State Under Executive Order 12372 Process?** Check c. Program is not covered by E.O. 12372

20. **Is the Applicant Delinquent on any Federal Debt?** (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

21. **Authorized Representative**: (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

b. Standard Form 424A

NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this AoA program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the

SF 424A should reflect a one year budget.

Section A - Budget Summary

Line 5: Leave columns (c) and (d) blank. Enter TOTAL Federal costs in column (e) and total non-Federal costs (including third party in-kind contributions and any program income to be used as part of the grantee match) in column (f). Enter the sum of columns (e) and (f) in column (g).

Section B - Budget Categories

Column 3: Enter the breakdown of how you plan to use the Federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-Federal share by object class category.

Column 5: Enter the total funds required for the project (sum of Columns 3 and 4) by object class category.

Separate Budget Narrative/Justification Requirement

Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: Federal; non-Federal cash; and non-Federal in-kind. Cost breakdowns, or justifications, are required for any cost of $1,000 or for the thresholds as established in the examples. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-Federal cash as well as, sub-contractor or sub-grantee (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification The full Budget Narrative/Justification should be included in the application immediately following the SF 424 forms.

Line 6a: **Personnel**: Enter total costs of salaries and wages of applicant/grantee staff. Do not include the costs of consultants, which should be included under 6h - Other.
In the Justification: Identify the project director, if known. Specify the key staff, their titles, and time commitments in the budget justification.

Line 6b: **Fringe Benefits**: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate.
In the Justification: If the total fringe benefit rate exceeds 35% of Personnel costs, provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement, etc. A percentage of 35% or less does not require a break down but you must show the percentage charged for each full/part time employee.

Line 6c: **Travel**: Enter total costs of all travel (local and non-local) for staff on the project. NEW: Local travel is considered under this cost item not under Other. Local transportation (all travel which does not require per diem is considered local travel). Do not enter costs for consultant's travel - this should be included in line 6h.
In the Justification: Include the total number of trips, number of travelers, destinations, purpose (e.g., attend conference), length of stay, subsistence allowances (per diem), and transportation costs (including mileage rates).

Line 6d: **Equipment**: Enter the total costs of all equipment to be acquired by the project. For all grantees, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. If the item does not meet the $5,000 threshold, include it in your

budget under Supplies, line 6e.

In the Justification: Equipment to be purchased with federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions. Further, the purchase of specific items of equipment should not be included in the submitted budget if those items of equipment, or a reasonable facsimile, are otherwise available to the applicant or its sub-grantees.

Line 6e: **Supplies**: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d.

In the Justification: . For any grant award that has supply costs in excess of 5% of total direct costs (Federal or Non-Federal), you must provide a detailed break down of the supply items (e.g., 6% of $100,000 = $6,000 – breakdown of supplies needed). If the 5% is applied against $1 million total direct costs (5% x $1,000,000 = $50,000) a detailed breakdown of supplies is not needed. Please note: any supply costs of $5,000 or less regardless of total direct costs does not require a detailed budget breakdown (e.g., 5% x $100,000 = $5,000 – no breakdown needed).

Line 6f: **Contractual**: Regardless of the dollar value of any contract, you must follow your established policies and procedures for procurements and meet the minimum standards established in the Code of Federal Regulations (CFR's) mentioned below. Enter the total costs of all contracts, including (1) procurement contracts (except those which belong on other lines such as equipment, supplies, etc.). Note: The 33% provision has been removed and line item budget detail is not required as long as you meet the established procurement standards. Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals on this line.

In the Justification: Provide the following three items – 1) Attach a list of contractors indicating the name of the organization; 2) the purpose of the contract; and 3) the estimated dollar amount. If the name of the contractor and estimated costs are not available or have not been negotiated, indicate when this information will be available. The Federal government reserves the right to request the final executed contracts at any time. If an individual contractual item is over the small purchase threshold, currently set at $100K in the CFR, you must certify that your procurement standards are in accordance with the policies and procedures as stated in 45 CFR 74.44 for non-profits and 92.36 for states, in lieu of providing separate detailed budgets. This certification should be referenced in the justification and attached to the budget narrative.

Line 6g: **Construction**: Leave blank since construction is not an allowable costs for this program.

Line 6h: **Other**: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits),non-contractual fees and travel paid directly to *individual* consultants, postage, space and equipment rentals/lease, printing and publication, computer use, training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is

where it belongs.

In the Justification: Provide a reasonable explanation for items in this category. For example, individual consultants explain the nature of services provided and the relation to activities in the work plan or indicate where it is described in the work plan. Describe the types of activities for staff development costs.

Line 6i: **Total Direct Charges**: Show the totals of Lines 6a through 6h.

Line 6j: **Indirect Charges**: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency; or (2) the applicant is a state or local government agency. **State governments should enter the amount of indirect costs determined in accordance with DHHS requirements.** An applicant that will charge indirect costs to the grant must enclose a copy of the current rate agreement. Indirect Costs can only be claimed on Federal funds, more specifically, they are to only be claimed on the Federal share of your direct costs. Any unused portion of the grantee's eligible Indirect Cost amount that are not claimed on the Federal share of direct charges can be claimed as un-reimbursed indirect charges, and that portion can be used towards meeting the recipient match.

Line 6k: **Total**: Enter the total amounts of Lines 6i and 6j.

Line 7: **Program Income**: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project that you wish to designate as match (equal to the amount shown for Item 15(f) on Form 424). **Note:** Any program income indicated at the bottom of Section B and for item 15(f) on the face sheet of Form 424 will be included as part of non-Federal match and will be subject to the rules for documenting completion of this pledge. If program income is expected, but is not needed to achieve matching funds, **do not** include that portion here or on Item 15(f) of the Form 424 face sheet. Any anticipated program income that will not be applied as grantee match should be described in the Level of Effort section of the Program Narrative.

Section C - Non-Federal Resources

Line 12: Enter the amounts of non-Federal resources that will be used in carrying out the proposed project, by source (Applicant; State; Other) and enter the total amount in Column (e). Keep in mind that if the match requirement is not met, Federal dollars may be reduced.

Section D - Forecasted Cash Needs - Not applicable.

Section E - Budget Estimate of Federal Funds Needed for Balance of the Project

Line 20: Section E is relevant for multi-year grant applications, where the project period is 24 months or longer. This section does not apply to grant awards where the project period is less than 17 months.

Section F - Other Budget Information

Line 22: Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final or fixed) to be in effect during the funding period, the base to which the rate is applied, and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

Line 23: Remarks: Provide any other comments deemed necessary.

c. Standard Form 424B - Assurances

This form contains assurances required of applicants under the discretionary funds programs administered by the Administration on Aging. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

d. Certification Regarding Lobbying

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

Proof of Non-Profit Status
Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.
- A statement from a State taxing body, State attorney general, or other appropriate State official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

Indirect Cost Agreement
Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency. This is optional for applicants that have not included indirect costs in their budgets.

Attachment B: Budget Narrative/Justification – Page 1 – Sample Format

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	$47,700	$23,554	$0	$71,254	**Federal** Project Director (name) = .5 FTE @ $95,401/yr = $47,700 **Non-Fed Cash** Officer Manager (name) = .5FTE @ $47,108/yr = $23,554 Total $71,254
Fringe Benefits	$17,482	$8,632	$0	$26,114	**Federal** Fringe on Project Director at 36.65% = $17,482 FICA (7.65%) Health (25%) Dental (2%) Life (1%) Unemployment (1%) **Non-Fed Cash** Fringe on Office Manager at 36.65% = $8,632 FICA (7.65%) Health (25%) Dental (2%) Life (1%) Unemployment (1%)
Travel	$4,707	$2,940	$0	$7,647	**Federal** Local travel: 6 TA site visits for 1 person Mileage: 6RT @ .585 x 700 miles $2,457 Lodging: 15 days @ $110/day $1,650 Per Diem: 15 days @ $40/day $600 Total $4,707 **Non-Fed Cash** Travel to National Conference in (Destination) for 3 people Airfare 1 RT x 3 staff @ $500 $1,500 Lodging: 3 days x 3 staff @ $120/day $1,080 Per Diem: 3 days x 3 staff @ $40/day $360 Total $2,940

Attachment B: Budget Narrative/Justification – Page 2 – Sample Format

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Equipment	$10,000	$0	$0	$10,000	*No Equipment requested OR:* Call Center Equipment Installation = $5,000 Phones = $5,000 Total $10,000
Supplies	$3,700	$5,784	$0	$9,484	**Federal** 2 desks @ $1,500 $3,000 2 chairs @ $300 $600 2 cabinets @ $200 $400 **Non-Fed Cash** 2 Laptop computers $3,000 Printer cartridges @ $50/month $300 Consumable supplies (pens, paper, clips etc…) @ $182/month $2,184 Total $9,484
Contractual	$30,171	$0	$0	$30,171	(organization name, purpose of contract and estimated dollar amount) Contract with AAA to provide respite services: 11 care givers @ $1,682 = $18,502 Volunteer Coordinator = $11,669 Total $30,171 *If contract details are unknown due to contract yet to be made provide same information listed above and:* A detailed evaluation plan and budget will be submitted by (date), when contract is made.

Attachment B: Budget Narrative/Justification – Page 3 – Sample Format

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Other	$5,600	$0	$5,880	$11,480	**Federal** 2 consultants @ $100/hr for 24.5 hours each = $4,900 Printing 10,000 Brochures @ $.05 = $500 Local conference registration fee (name conference) = $200 Total $5,600 **In-Kind** **Volunteers** 15 volunteers @ $8/hr for 49 hours = $5,880
Indirect Charges	$20,934	$0	$0	$20,934	21.5 % of salaries and fringe = $20,934 IDC rate is attached.
TOTAL	$140,294	$40,910	$5,880	$187,084	

Attachment C: Budget Narrative/Justification — Sample Template

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel					
Fringe Benefits					
Travel					
Equipment					
Supplies					
Contractual					
Other					
Indirect Charges					
TOTAL					

Attachment D: Project Work Plan, Page 1 – Sample Template

Goal:
Measurable Outcome(s):

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	Lead Person	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
1.														
2.														

Attachment D: Project Work Plan, Page 2 – Sample Template

Goal:
Measurable Outcome(s):

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	Lead Person	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
3.														
4.														

Attachment D: Project Work Plan, Page 3 – Sample Template

Goal:
Measurable Outcome(s):

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	Lead Person	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
5.														
6.														

NOTE: Please do note infer from this sample format that your work plan must have 6 major objectives. If you need more pages, simply repeat this format on additional pages.

Attachment E: Instructions for Completing the Project Summary/Abstract

- All applications for grant funding must include a Summary/Abstract that concisely describes the proposed project. It should be written for the general public.
- To ensure uniformity, please limit the length to no more than 265 words on a single page with a font size of not less than 11, doubled-spaced.
- The abstract must include the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. The following are very simple descriptions of these terms, and a sample Compendium abstract.

  Goal(s) – broad, overall purpose, usually in a mission statement, i.e. what you want to do, where you want to be

  Objective(s) – narrow, more specific, identifiable or measurable steps toward a goal. Part of the planning process or sequence (the "how"). Specific performances which will result in the attainment of a goal.

  Outcomes - measurable results of a project. Positive benefits or negative changes, or measurable characteristics that occur as a result of an organization's or program's activities. (outcomes are the end-point)

  Products – materials, deliverables.

- A model abstract/summary is provided below:

The grantee, Okoboji University, supports this three year Dementia Disease demonstration (DD) project in collaboration with the local Alzheimer's Association and related Dementias groups. The **goal** of the project is to provide comprehensive, coordinated care to individuals with memory concerns and to their caregivers. The approach is to expand the services and to integrate the bio-psycho-social aspects of care. The **objectives** are: 1) to provide dementia specific care, i.e., care management fully integrated into the services provided; 2) to train staff, students and volunteers; 3) to establish a system infrastructure to support services to individuals with early stage dementia and to their caregivers; 4) to develop linkages with community agencies; 5) to expand the assessment and intervention services; 6) to evaluate the impact of the added services; 7) to disseminate project information. The expected **outcomes** of this DD project are: patients will maintain as high a level of mental function and physical functions (thru Yoga) as possible; caregivers will increase ability to cope with changes; and pre and post – project patient evaluation will reflect positive results from expanded and integrated services. The **products** from this project are: a final report, including evaluation results; a website; articles for publication; data on driver assessment and in-home cognitive retraining; abstracts for national conferences.

Attachment F: MIPPA Application Cover Sheet

2010 MIPPA Funding Opportunity

Application Cover Sheet

Priority Area 1

Lead Agency:
Address:
Key Contact Name and Title:
E-mail:
Phone:
Fax:
Agency EIN: (include any agency suffix qualifier as appropriate)

Priority Areas 2 and 3

Lead Agency:
Address:
Key Contact Name and Title:
E-mail:
Phone:
Fax:
Agency EIN: (include any agency suffix qualifier as appropriate)

Lead Organization Responsible for Submitting Application and Performance Reports

Agency Name:

Statement of Collaboration

The key contact from each agency listed above should sign below. Where one state agency is applying for all three priority areas, only one signature will be required, two state applicant agencies will require two signatures.

We the undersigned, representing the key state agencies partnering to implement the 2010 MIPPA funding opportunity, agree that this application represents a collaborative effort that will be coordinated across key agencies. We further agree to cooperate fully with CMS, AoA and the NCBOE in the implementation of this project.

_____ _____

Agency 1 Agency 2

Attachment G: MIPPA Funding Allocation By State

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) as amended by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act)

Priority	Priority 1	Priority 2	Priority 3	Total by State
Sub Recipient	**SHIP**	**AAA**	**ADRC**	
Target Population	**LIS / MSP Medicare Part D Part D/Rural**	**LIS / MSP Medicare Part D Part D/Rural**	**Medicare Part D MSP**	
Total MIPPA Amounts	**$15,000,000**	**$15,000,000**	**$10,000,000**	**$40,000,000**
Tribal Set Aside	**$0**	**$246,000**	**$0**	**$246,000**
Total to be Distributed	**$15,000,000**	**$14,754,000**	**$10,000,000**	**$39,754,000**

Detailed MIPPA Funding Allocation by State

State	Priority 1 (SHIP)	Priority 2 (AAA)	Priority 3 (ADRC)	Total by State
Alabama	$376,507	$373,276	$139,704	$889,487
Alaska	$21,645	$11,512	$30,990	$64,147
American Samoa	$0	$179	$0	$179
Arizona	$205,316	$194,045	$326,612	$725,973
Arkansas	$320,136	$268,516	$252,679	$841,331
California	$671,617	$897,032	$578,709	$2,147,358
Colorado	$136,462	$138,972	$69,638	$345,072
Connecticut	$90,896	$116,724	$227,585	$435,205
Delaware	$44,097	$37,744	$0	$81,841
District Of Columbia	$23,822	$27,509	$37,116	$88,447
Florida	$645,603	$762,657	$595,847	$2,004,107
Georgia	$519,311	$456,827	$488,268	$1,464,406
Guam	$5,312	$750	$5,678	$11,740
Hawaii	$35,917	$24,011	$82,024	$141,952
Idaho	$115,346	$79,169	$16,834	$211,349
Illinois	$529,081	$522,025	$416,723	$1,467,829
Indiana	$432,664	$410,887	$477,750	$1,321,301
Iowa	$235,912	$181,041	$27,876	$444,829
Kansas	$196,213	$164,128	$49,880	$410,221
Kentucky	$503,491	$416,525	$360,713	$1,280,729
Louisiana	$316,982	$309,942	$324,923	$951,847
Maine	$154,556	$122,097	$110,681	$387,334
Maryland	$154,274	$188,466	$242,195	$584,935
Massachusetts	$221,842	$265,779	$502,921	$990,542
Michigan	$582,358	$598,432	$0	$1,180,790

Minnesota	$247,248	$218,380	$371,667	$837,295
Mississippi	$331,892	$261,837	$49,340	$643,069
Missouri	$407,660	$365,235	$0	$772,895
Montana	$88,633	$62,451	$25,525	$176,609
Nebraska	$112,702	$86,384	$0	$199,086
Nevada	$66,956	$69,854	$123,040	$259,850
New Hampshire	$93,897	$79,006	$103,096	$275,999
New Jersey	$198,890	$282,047	$225,117	$706,054
New Mexico	$122,248	$93,948	$147,923	$364,119
New York	$802,095	$921,030	$794,246	$2,517,371
North Carolina	$731,241	$681,256	$339,537	$1,752,034
North Dakota	$47,676	$39,041	$0	$86,717
Northern Mariana Islands	$0	$85	$770	$855
Ohio	$581,842	$602,233	$99,662	$1,283,737
Oklahoma	$279,033	$242,340	$0	$521,373
Oregon	$212,642	$182,448	$0	$395,090
Pennsylvania	$779,613	$841,669	$167,733	$1,789,015
Puerto Rico	$52,069	$41,690	$0	$93,759
Rhode Island	$42,392	$51,165	$86,874	$180,431
South Carolina	$309,693	$299,177	$215,025	$823,895
South Dakota	$63,714	$47,852	$0	$111,566
Tennessee	$506,287	$457,887	$174,944	$1,139,118
Texas	$906,642	$934,296	$820,616	$2,661,554
Utah	$73,970	$59,292	$0	$133,262
Vermont	$58,567	$40,769	$34,617	$133,953
Virgin Islands	$7,051	$1,073	$0	$8,124
Virginia	$373,005	$361,165	$283,720	$1,017,890
Washington	$265,963	$257,873	$54,619	$578,455
West Virginia	$179,444	$139,722	$181,958	$501,124
Wisconsin	$475,584	$437,004	$334,625	$1,247,213
Wyoming	$41,991	$27,546	$0	$69,537
Total to be Distributed	**$15,000,000**	**$14,754,000**	**$10,000,000**	**$39,754,000**

Attachment H: Options Counseling Cooperative Agreement

"Implementing the Affordable Care Act to make it easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access; ADRCs Option Counseling and Assistance Programs"

(HHS-2010-AOA-OC-1025)

Consistent with the Federal Grant and Cooperative Agreement Act of 1977 (P.L. 95-224), the **(Grantee name)**, also herein referred to as the **grantee**, has received a Notice of Award to establish a Cooperative Agreement between the Administration on Aging (AoA) and the **grantee**. This Cooperative Agreement, whose terms are described below, provides for the substantial involvement and collaboration of AoA in activities the recipient organization will complete in accordance with the provisions of the approved grant award.

Grantee Responsibilities
As proposed in its approved application, the **grantee** agrees to carry out the objectives and activities of the project announced as the *"Implementing the Affordable Care Act to make it easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access; ADRCs Option Counseling and Assistance Programs"* The **grantee** will enhance and implement in ADRC Options Counseling and Assistance models in accordance with the following conditions described in this Program Announcement:

1. The grantee must – at a minimum - involve a full partnership of the State Unit on Aging, the State Medicaid Agency and State Disability Agencies where applicable, and at the community level, a substantive role for the ADRC statewide advisory committee or the local ADRC advisory committee, any Area Agency on Aging, Local Medicaid Office, Center for Independent Living, State Health Insurance Counseling Program, and Benefits Outreach and Enrollment Center, where applicable, located in the geographic areas covered by a state's ADRC Program. Applications must also include a substantive advisory role for consumers, their families and other key stakeholders affected by a state's ADRC to assist the state in the enhancement and expansion of its ADRC program.

Projects to be funded under this Announcement must:

1. Develop and implement standard operating procedures for options counseling (or strengthen/refine existing standards) for the grantee's state ADRC network. Grantees will spend the first year of the grant period developing and implementing standard operating procedures (SOPs) for their ADRCs that specify how options counseling will be delivered, by whom, to whom, under what circumstances, and how it will be tracked and outcomes monitored. Ideally, states will implement these new standards statewide, but, at a minimum, they should be implemented in ADRCs that serve two distinct regions of their state. Over the second year of the grant, grantees will monitor and track delivery of options counseling to evaluate the impact of the new standards in terms of business

operations (e.g. effectiveness of referral protocols, client to staff ratios) and consumer outcomes (e.g. greater sense of empowerment, satisfaction with service and support choices made, integration into the community). Participate in a collaborative process with other grantees, federal agency staff, TA providers and other stakeholders to develop a set of minimum national standards for options counseling.

2. Creation of National Standards for Options Counseling and Assistance which includes defining a set of minimum national standards for the delivery of options counseling, core competencies, minimum qualifications required for options counselors, and protocols for client tracking and performance measurement document in a collaborative process with other grantees, federal agency staff, TA providers, and other stakeholders.

3. Grantees agree to prepare and submit a final report that:

- Summarizes feedback gathered from program managers, options counselors and other stakeholders about the process of implementing the standard operating procedures and how they work;
- Summarizes evaluation findings about service delivery and consumer outcomes (over a period of at least 12 months);
- Outlines how their state's standard operating procedures already meet or will be revised to meet the minimum national standards developed by the group of grantees.
- Outlines a recruitment and/or training plan for ensuring all options counselors across the state meet minimum qualifications by 2014 (or as part of statewide ADRC implementation);
- Specifies the different funding streams to be used to pay for options counseling going forward;

4. Provides recommendations for how the national standards developed by the group of grantees might be implemented nationwide.

5. Applicants seeking funding under this option must be expanding and enhancing their ADRC projects Options Counseling and Assistance model within the framework established under the AoA and CMS ADRC Program Announcements published in 2003, 2005 and 2009 within the operational examples provided.

6. Agree to work with AoA, the Technical Assistance Center, and the other ADRC grantees to identify and collect common measures.

7. Fully coordinate the project(s) with other state-administered long-term service and supports and rebalancing efforts.

The **grantee** agrees that activities under this initiative will not duplicate activities funded under other resources.

AoA Responsibilities

The Administration on Aging agrees to work cooperatively in the development and execution of the activities of the project as follows:

A. AoA Project Officer will perform the day-to-day Federal responsibilities of managing the Aging and Disability Resource Grants Program and enhancement opportunities.

B. AoA and the **grantee** will work cooperatively to clarify the programmatic and budgetary issues to be addressed by the project. Based on these negotiations, the **grantee** will revise the project work plan detailing expectations for major activities and products during the 24 month grant. The work plan will include key tasks, timelines, and staff assignments. AoA or the **grantee** can propose a revision in the final work plan at any time. Any changes in the final work plan will require agreement of both parties.

C. AoA will assist the **grantee** project leadership in understanding the policy concerns and/or priorities of AoA by conducting periodic briefings and by carrying out ongoing consultations.

AoA will work with the **grantee** to ensure that the minimum requirements of the grant are met. Particular attention will be paid to the grantees ability to Develop and implement standard operating procedures for options counseling (or strengthen/refine existing standards) for the grantee's state ADRC network and participate in a collaborative process with other grantees, federal agency staff, TA providers and other stakeholders to develop a set of minimum national standards for options counseling.

D. AoA will work with the **grantee** on the development and implementation of evaluation and quality assurance systems in an effort to ensure consistency with program goals and the activities of other ADRC grantees.

E. AoA will designate technical assistance providers to design and implement, in cooperation with AoA**,** technical assistance to support grantee activities.

The grant period for this project is up to 24 months beginning no later than **Sept 30, 2010**

Requests to modify or amend this Cooperative Agreement may be made at any time by AoA or the grantee. Any modifications and/or amendments shall be effective upon the mutual agreement of both parties.

Draw down of funding for this grant through the Federal Payment Management System serves as official acceptance of this Cooperative Agreement. If you do not plan to accept the grant award, please send a letter of declination to the AoA Grants Management Officer with a copy to the AoA Project Officer within 30 days of receipt of the Notice of Award.

Attachment I: Money Follows the Person Awardees (2007)

State	Grantee Agency
Arkansas	Arkansas Department of Health and Human Services (ADHHS), Division of Aging and Adult Services (DAAS) in partnership with the Division of Medical Services (the State Medicaid agency), Behavioral Health Services (DBHS) and Developmental Disabilities Services (DDS)
California	California Department of Health Care Services
Connecticut	Connecticut Department of Social Services
District of Columbia	The DC Department of Health, Medical Assistance Administration (MAA), in collaboration with the Department of Mental Health (DMH), the Mental Retardation and Developmental Disabilities Administration (MRDDA, housed within the Department of Human Services), the DC Housing Authority, and the DC Office of Aging.
Delaware	Department of Health and Social Services, Division of Medicaid and Medical Assistance
Georgia	Georgia Department of Community Health (DCH), in collaboration with the Departments of Human Resources (DHR), Labor (DoL), and Community Affairs (DCA)
Hawaii	Hawaii Department of Human Services (DHS), in collaboration with the Developmental Disabilities Division of the Department of Health (DoH-DDD)
Illinois	The Department of Healthcare and Family Services (HFS), in collaboration with the Department on Aging (DoA), three divisions of the Department of Human Services ([DHS]; Divisions of Rehabilitation Services, Developmental Disabilities, and Mental Health), and the Illinois Housing Development Authority (IHDA)
Indiana	State of Indiana Family and Social Services Administration
Iowa	Iowa Department of Human Services
Kansas	Kansas Department of Social and Rehabilitation Services (SRS), in partnership with the Kansas Health Policy Authority (KHPA) and the Kansas Department on Aging (KDoA)
Kentucky	Department of Medicaid Services
Louisiana	Louisiana Medicaid, in partnership with the Office of Aging and Adult Services (OAAS) and the Office for Citizens with Developmental Disabilities (OCDD)
Maryland	Maryland Department of Health and Mental Hygiene

State	Grantee Agency
Michigan	Medical Services Administration (MSA) and the Office of Long-Term Care Supports and Services, within the Michigan Department of Community Health (MDCH).
Missouri	Missouri Department of Social Services (DSS), Division of Medical Services (DMS)
Nebraska	Nebraska Department of Health and Human Services (HHSS), Department of Finance and Support
New Hampshire	New Hampshire Department of Health and Human Services (DHHS)
New Jersey	New Jersey Department of Human Services (DHS)
New York	New York State Department of Health (NYS-DOH) and the Office of Long-Term Care (OLTC)
North Carolina	North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA)
North Dakota	North Dakota Department of Human Services, Medical Services Division
Ohio	Ohio Department of Job and Family Services (ODJFS)
Oklahoma	Oklahoma Health Care Authority (OHCA), in partnership with the Developmental Disability Services Division (DDSD) of the Department of Human Services, the Long-Term Care Authority (LTCA), and Progressive Independence (PI)
Oregon	Oregon Department of Human Services, Division of Seniors and People with Disabilities (SPD)
Pennsylvania	Pennsylvania Department of Public Welfare (DPW)
South Carolina	South Carolina Department of Health and Human Services (SCDHHS)
Texas	The Health and Human Services Commission (HHSC), the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), and the Department of Assistive and Rehabilitative Services (DARS), and the Department of State Health Services (DSHS)
Virginia	Department of Medical Assistance Services (DMAS)
Washington	The Aging and Disability Services Administration (ADSA)
Wisconsin	Wisconsin Department of Health and Family Services

Source:
http://www.cms.gov/CommunityServices/Downloads/StateMFPGrantSummaries-All.pdf

Attachment J: Evidence-Based Care Transition Models

Attachment J summarizes two hospital-to-home care transitions models and two models of care coordination that center on primary care. These are evidence-based models that applicants should consider. However, applicants may propose other evidence-based models. All applicants must provide a justification for the models that they choose to pursue.

Hospital-to-Home Care Transitions Models

Model	**Care Transitions Intervention (CTI)** (commonly called the "Coleman Model")	**Transitional Care Model (TCM)** (commonly called the "Naylor Model")
Short description	Transition Coach helps patients and families learn transition-specific self-management skills. The Transition Coach: - Conducts a hospital visit to introduce the program and tools such as the Personal Health Record (PHR) - Conducts one home visit 24-72 hours post-discharge: 1. Actively engages patients in medication reconciliation and how to respond to medication discrepancies; helps them develop a clear, easily understood medication regimen and enter into PHR. 2. Uses role-playing and other tools to transfer skills to patients and family members on how to communicate care needs effectively during subsequent encounters with health care professionals. 3. Reviews any "red flags" that indicate a worsening condition, and strategies for how to respond to these red flags should they manifest. - Performs three follow up phone calls to reinforce the coaching offered during the home visit and activation behavior. Calls focus on reviewing the patient's progress toward established goals, discussing any encounters with other health care professionals, reinforcing the importance of maintaining and sharing the personal health record, and	In this model, the Transitional Care Nurse: - Visits patient in the hospital to: 1. Conduct an in-hospital assessment (including detailed assessment of each patients' functional status) 2. Collaborate with care-team members to reduce adverse events and prevent functional decline 3. Develop a streamlined, evidenced-based plan of care - Conducts home visit within 24 hours of discharge to assess safety in completing ADLs and IADLs, recommend adaptations to the environment, and refer to other services - Accompanies patient on first visit with the physician post-discharge and subsequent visits if needed - Facilitates physician-nurse collaboration across episodes of acute care - Conducts weekly home visits for first month - Makes telephone contact for each week an in-person visit is not scheduled - Is on call seven days per week for home visits and telephone access - Provides active engagement of patients and family caregivers with focus on meeting their goals - Provides communication to, between, and among the patient, family caregivers, and health care providers.

Target population	Individuals 65 years or older, although applicable to younger populations as well. Patients should be community-dwelling adults with a working telephone. Appropriate for persons with depression or dementia provided they have a willing and able family caregiver.	Evaluation included cognitively intact older adults (program tested with patients 65 or older) with two or more risk factors, including: - Poor self-health ratings - Multiple chronic conditions - History of recent hospitalizations. - Currently being tested among cognitively impaired hospitalized older adults and long-term care recipients being transferred to and from acute care hospitals
Length of intervention	Four weeks	One to three months
Training	To be recognized as an official CTI adoption and ensure model fidelity to achieve improved outcomes, the CTI team offers a one-day training delivered by their staff either on-site or in Aurora (Denver) Colorado.	The team at U. of Penn has developed a series of web-based training modules that prepare nurses to become Transitional Care Nurses, plus training on the clinical information system. It takes, on average, one month to orient a new Transitional Care Nurse.
Qualification required of individual delivering intervention	Transition Coach needs strong interpersonal and communication skills, the ability to make the shift from doing things for patients to facilitating skill transfer so that patients can do more for themselves.	Transitional Care Nurse in published studies was an advanced practice nurse (had a masters degree in nursing with advanced knowledge and skills in serving older adults). Currently evaluating outcomes with bachelors-prepared nurses.
Estimated costs	From research study: The total annual intervention cost was $74,310 ($196 per patient).	From research study: The total annual intervention cost was $115,856 ($982 per patient).
Website	http://www.caretransitions.org	http://www.innovativecaremodels.com/care_models/21/overview

Practice-based Care Coordination Models that include Care Transitions Elements

Model	**Guided Care**	**Geriatric Resources for Assessment and Care of Elders (GRACE)**
Short description	Program requires that Guided Care Nurse: - Conduct a comprehensive home assessment - Create a care guide and an action plan for the patient - Provide monthly monitoring and self-management coaching - Smooth transitions into and out of hospitals and other institutions - Coordinate care by all providers - Provide family caregiver education/support - Facilitate access to community based services	Program requires that nurse practitioner and social worker: - Offer in-home assessment and care management - Collaborate with and support the primary care physician - Meet with the patient's primary care physician to review, modify and prioritize the care plan, then collaborate with the physician on putting it into practice - Work weekly with geriatrician-led interdisciplinary team to craft patient care plan - Conduct at least one in-home follow-up visit to review care plan, and one telephone or face-to-face contact per month. - Coordinate care from all providers - Collaborate with hospital discharge planners and make a home visit after any hospitalization
Target population	Evaluation included individuals age 65 years or older who were at high risk of using health services heavily during the following year, as estimated by the claims-based Hierarchical Condition Category (HCC) predictive model.	Evaluation included low-income older adults (65 or older) in primary care including a group at high risk of hospitalization as estimated by the probability of repeated admission risk screen.
Length of intervention	Long-term/indefinite; the length of contact with patient is usually for life.	Long-term/indefinite; the length of contact with patient in evaluation was two years.
Training	All candidates must complete the Johns Hopkins 6-week, 40-hour web-based course, pass an online exam, and earn a Certificate in Guided Care Nursing from the ANCC.	Nurse practitioners and social workers each complete a 12-session training program (with meetings held once a week) on implementing the GRACE protocols and working as part of an interdisciplinary team.
Qualification required of individual delivering intervention	Must be a registered nurse, ideally with experience in home care, case management, community health and/or equivalent gerontologic nursing.	Program utilizes nurse practitioner and social worker who work with the primary care physician, geriatrician, and other relevant health professional in a team-based approach.
Estimated costs	From research study: Total annual intervention cost was $95,900 ($1,743 per patient).	From research study: Total annual intervention costs for high-risk patients: $315,040 ($1,432 per patient).
Website	http://www.guidedcare.org/	http://medicine.iupui.edu/IUCAR/research/grace.asp

Attachment K: Care Transitions Cooperative Agreement

"Implementing the Affordable Care Act to make it easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access; ADRCs Evidence-based Care Transition Programs"

(HHS-2010-AOA-CT-1026)

Consistent with the Federal Grant and Cooperative Agreement Act of 1977 (P.L. 95-224), the **(Grantee name)**, also herein referred to as the **grantee**, has received a Notice of Award to establish a Cooperative Agreement between the Administration on Aging (AoA) and the **grantee**. This Cooperative Agreement, whose terms are described below, provides for the substantial involvement and collaboration of AoA in activities the recipient organization will complete in accordance with the provisions of the approved grant award.

Grantee Responsibilities
As proposed in its approved application, the grantee agrees to carry out the objectives and activities of the project announced as "Implementing the Affordable Care Act to make it easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access; ADRC Evidence-based Care Transition Program.

AoA is making funds available for States to further expand and enhance the roles of ADRCs in care transitions initiatives in an effort to help persons of all ages – regardless of disability, geographic location, or income level – to live in the community, improve or maintain their level of independence, and avoid hospitalization and other institutionalization.

The grantee must – at a minimum - involve a full partnership of the State Unit on Aging, the State Medicaid Agency, State Quality Improvement Organization (QIO) and State Disability Agencies where applicable, and at the community level, a substantive role for any Area Agency on Aging, Local Medicaid Office, Center for Independent Living, State Health Insurance Assistance Program, and Benefits Outreach and Enrollment Center (where applicable), located in the geographic areas covered by a State's ADRC Program. Applications must also include a substantive advisory role for consumers, their families and other key stakeholders affected by a state's ADRC to assist the state in the development and implementation of its ADRC program.

Projects to be funded under this Announcement must:

1. Further develop and enhance the ADRC participation in evidence-based care transition models. This may include:

- Increasing the capacity of ADRCs' current involvement in evidence-based care transition initiatives by expanding the reach of the ADRC efforts (e.g., adding additional staff or expanding to new regions or to additional hospitals)
- Strengthening the extent to which existing transitions programs leverage the assets of the ADRCs (e.g., to streamline access to public benefits, link individuals with community-based services and supports, and counsel individuals and their families on service options) among programs where ADRCs have a limited role currently.
- Informing AoA/CMS, other Federal agencies and Congress on national policy related to care transitions, hospital discharge planning, person-centered planning, and mechanisms to reduce unnecessary hospital re-admissions

2. Support ADRC's development and enhancement of *evidence-based* care transition models. Applicants can propose to use other models but must justify with documentation the evidence that the proposed models reduce hospital readmissions, improve participant quality of life, are person- centered, and involve formal linkages with community programs.

3. Have established partnerships with one or more hospitals, clinics, or physician practices related to the implementation of care transitions activities.

4. In partnership with other key agency partners, funds could be used to hire and directly manage care transitions workers and or funding care transitions staff at other organizations and actively collaborating with existing care transitions project.

5. Report consistent data collection processes and outcome measures, share lessons learned, support the development of care transitions activities at new sites across the country and define a core set of expectations for how ADRCs should be involved in/support care transitions activities.

6. Formalized MOUs with all entities involved in project

7. Develop and implement a formal evaluation to assess fidelity to the evidence-based model, document changes in hospital re-admission rates, and monitor other outcomes including providing:
    - Evidence that the health and well being of individuals transitioning from different care settings has improved
    - Evidence that rates of hospital re-admissions have declined
    - Documentation of efficiency and/or cost savings by the end of project

8. Final report that summarizes lessons learned, documents the number of people assisted during the project, and provides recommendations for how ADRCs may support evidence-based care transition and care coordination activities nationwide

9. Agree to work with AoA, the Technical Assistance Center, and the other ADRC grantees to identify and collect common measures.

10. Fully coordinate the project(s) with other state-administered long-term service and supports and rebalancing efforts.

The **grantee** agrees that activities under this initiative will not duplicate activities funded under other resources.

AoA Responsibilities

The Administration on Aging agrees to work cooperatively in the development and execution of the activities of the project as follows:

A. AoA Project Officer will perform the day-to-day Federal responsibilities of managing the Aging and Disability Resource Grants Program.

B. AoA and the **grantee** will work cooperatively to clarify the programmatic and budgetary issues to be addressed by the project. Based on these negotiations, the **grantee** will revise the project work plan detailing expectations for major activities and products during the 24 month grant. The work plan will include key tasks, timelines, and staff assignments. AoA or the **grantee** can propose a revision in the final work plan at any time. Any changes in the final work plan will require agreement of both parties.

C. AoA will assist the **grantee** project leadership in understanding the policy concerns and/or priorities of AoA by conducting periodic briefings and by carrying out ongoing consultations.

D. AoA will work with the **grantee** to ensure that the minimum requirements of the grant are met. Particular attention will be paid to the grantees ability to develop and enhance the ADRC participation in evidence-based care transition models.

E. AoA will work with the **grantee** on the development and implementation of evaluation and quality assurance systems in an effort to ensure consistency with program goals and the activities of other ADRC grantees.

F. AoA will designate technical assistance providers to design and implement, in cooperation with AoA**,** technical assistance to support grantee activities.

The grant period for this project is up to 24 months beginning no later than **September 30, 2010**.

Requests to modify or amend this Cooperative Agreement may be made at any time by AoA or the grantee. Any modifications and/or amendments shall be effective upon the mutual agreement of both parties.

Draw down of funding for this grant through the Federal Payment Management System serves as official acceptance of this Cooperative Agreement. If you do not plan to accept the grant award, please send a letter of declination to the AoA Grants Management Officer with a copy to the AoA Project Officer within 30 days of receipt of the Notice of Award.

Attachment L: Center for Technology and Aging Funding Opportunity

Special Opportunity to Participate in
The Center for Technology and Aging Tech4Impact Diffusion Grants Program:
Technologies for **Im**proving Post-**A**cute **C**are **T**ransitions
For Older Adults and Persons with Disabilities

Key Dates:

Notice of Intent to Apply:	July 1, 2010
Grant Application Release Date:	September 30, 2010
Grant Application Due Date:	October 15, 2010
Issuance of Notice of Grant Awards:	Prior to December 31, 2010

Funding Summary:

Award Type:	Grants
Funds available:	Approximately $600,000
Est. Number of Awards:	Approximately 6
Eligible Applicants:	A State agency or instrument of a State who is applying for the *Implementing the Affordable Care Act to make it easier for 'Individuals to Navigate their Health and Long-Term Care through Statewide Systems of Information- Option D'* component of the program announcement.
Est. Total Award:	Approximately $100,000 for 12-month period
Project Period Length:	12 months

The AoA, CMS and Center for Technology and Aging Intent

As a complement to the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) Program Announcement, *Implementing the Affordable Care Act to make it easier for Individuals to Navigate their Health and Long-Term Care through Statewide Systems of Information, Counseling and Access*, the Center for Technology and Aging (CTA) will offer funding through the **Tech4Impact Diffusion Grants Program** to help states further strengthen efforts to improve evidence-based care transition programs. CTA will make **Tech4Impact** funds available to states that are awarded grants by AoA/CMS for program Option D: ADRCs Evidence-Based Care Transition Programs ("Option D"). This special opportunity will help selected states expand the use of technologies that assist older adults and persons with disabilities make a safe, effective and satisfactory transition from hospital, rehabilitation or skilled nursing facilities to home and prevent avoidable re-hospitalization.

The United States has an 18% rate of hospital readmissions within 30 days of discharge—and as many as 76% of these are preventable. According to Medicare data, a majority (64%) of readmitted patients received no care or follow-up in the 30 days after hospitalization. Of those that did receive care, the care was often fragmented and uncoordinated—sometimes resulting in duplication of services, inappropriate or conflicting care recommendations, medication errors, patient/caregiver distress, and higher costs of care. Recent studies suggest that interventions targeted toward care transitions from hospital to home or to long-term care can reduce readmission rates by one-third. These interventions focus on improving the care transitions process, providing direct patient support, improving self-management skills, and increasing access to needed information and tools.

What is the Purpose of the Tech4Impact Diffusion Grants Program?
The purpose of the **Tech4Impact** Diffusion Grants Program is to accelerate adoption and diffusion of technologies that better enable evidence-based care transitions models, and result in a reduction in avoidable hospitalizations, improvements in health outcomes and cost of care, and an increase in the number of people that are able to safely and effectively transition from hospital to home or to long-term care community settings.

Who is Eligible to Apply for the Tech4Impact Diffusion Grants Program?
States that apply for Option D are eligible to apply for CTA's **Tech4Impact** Diffusion Grants Program.

How Do Eligible Organizations Apply for Tech4Impact Grant Funds?
To apply for **Tech4Impact** grant funds, eligible organizations must submit a one-page letter of intent along with their Option D application (see description below). This will not count toward the 10-page limit required for an Option D submission. The letter of intent will be forwarded to CTA for review and consideration.

Who May Receive Tech4Impact Awards?
Grant recipients who are approved by AoA/CMS for Option D funding will become eligible to receive **Tech4Impact** awards.

What are the allowable activities that can be paid for with Tech4Impact Awards?
Tech4Impact funds may be used to support community-based interventions that align with the goals of the **Tech4Impact** program: to accelerate adoption and diffusion of technologies that better enable evidence-based care transitions models. Example activities or interventions include, but are not limited to, the use of medical devices and computer-based technologies that better enable:

- Medication adherence (e.g., devices that remind patients to take the right medication at the right time and alert caregivers when a medication has not been taken)
- Medication reconciliation (e.g., software that stores medication information and detects potential problems, such as duplicate prescriptions)
- Patient or caregiver access to health records and other important health information

- Home monitoring of a patient's health condition, including technologies that provide an early warning alert when a patient's health condition deteriorates
- Health risk assessments (e.g., to identify pre-discharge patients most at risk of hospital readmission).
- Communications between and among patients and informal caregivers, and formal caregivers

CTA may also consider funding the following technology-enabled activities:

- Training and supervision of personnel implementing one of the care transitions models (e.g., Care Transition Intervention or Transitional Care Model)
- Care transitions program evaluations that will guide and improve program quality

Note that grant funding cannot be used to pay for technology equipment.

Standards: State Units on Aging and ADRC grant recipients who are approved by AoA/CMS for Option D funding will become eligible to receive a **Tech4Impact** award. **Tech4Impact** applicants that will be given highest consideration include those that 1) have in place the basic elements of an evidence-based care transitions program and understand how technology can complement the program, 2) have demonstrated ability to work collaboratively with local organizations to implement a care transitions program, and, 3) have developed a plan for long-term sustainability.

Target Population:
Tech4Impact funds are intended for older adults or persons with disabilities participating in, or who could benefit from, an Evidence-Based Care Transition program (e.g., Care Transitions Interventions, Transitional Care Model, Geriatric Resources for Assessment and Care of Elders, or evidence-based models)

Tech4Impact Diffusion Grants Program Application Process:
To apply for Tech4Impact funding, organizations must address a Letter of Intent to CTA and append it to their AoA/CMS Option D application. The Letter of Intent will be forwarded to CTA for review and consideration. CTA will then invite selected states to submit full applications for the **Tech4Impact** Diffusion Grants Program. The Center will release the guidelines for developing a full application by September 30, 2010. Full applications will be due October 15, 2010.

Tech4Impact funds must be primarily directed toward community-based projects that help people make care transitions from hospital to home or to long-term care. Hence, the Letter of Intent must describe the evidence -based project(s) for which funds are sought. For each project, include a brief description of the:

- Project summary and goals;
- Care transitions intervention model to be utilized (e.g. CTI, CTM, G.R.A.C.E, etc);
- Technology selected to enable the intervention;
- Rationale for selecting this technology;

- Target audience (e.g., who, where—geography and care setting, how many);
- Key project personnel;
- Key partners; and,
- Capabilities and commitment of project personnel and collaborators.

Tech4Impact Award:
The Center for Technology and Aging will award up to 6 grants through the **Tech4Impact** Diffusion Grants Program. CTA will consider funding up to $100,000 for each community-based project. Applicant's eligibility and receipt of an award from the CTA for this option is dependent upon receiving an AoA/CMS Implementing the Affordable Care Act grant award. The **Tech4Impact** awards will be made no later than December 31, 2010.

Collaboration between U.S. Administration on Aging (AoA), the Centers for Medicare & Medicaid Services (CMS), and the Center for Technology and Aging (CTA)
CTA supports AoA and CMS's long range vision to have ADRC programs fully operational and available to individuals in every community across the country, serving as highly visible and trusted sources of objective information on the full range of long-term services and support options and help in accessing the services and supports they need. ADRCs are community-wide "programs" or "systems" of information, counseling and access that work in a coordinated manner to provide consumers with a "single point of entry" to all long-term services and supports, including all publicly supported programs, both community based and institutional care. From the perspective of the consumer, ADRCs are intended to provide seamless access to long-term services and supports and be supportive of the care transition process.

CTA (www.techandaging.org) supports more rapid adoption and diffusion of technologies that enhance independence and improve home and community-based care for older adults and persons with disabilities. Through grants, research, public policy involvement and development of practical tools and best practice guidelines, the Center serves as an independent, non-profit resource for improving the quality and cost-effectiveness of long-term care services.

Center for Technology and Aging/Tech4Impact Contacts:

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Attachment M: Voluntary Semi-Annual Reporting Process for ADRC

ADRC grantees that receive additional funding through one or all of the 2010 Program Announcements will be asked to report narrative and quantitative data about *all* their ADRC-related activities in one report to AoA and CMS every six months, through the web-based Semi-Annual Reporting Tool (SART).

While there will be no separate semi-annual reporting requirement for these grants, grantees may be asked to respond to a few additional questions through the SART depending on which grant funds they receive in 2010. See ***Exhibits 1 and 2*** below for detail about the narrative and quantitative questions currently included in the SART and how these are likely to be expanded to capture information about these grant activities.

Grantees will be provided with advance notice of any changes made to the SART going forward. Grantees will be provided with a guide with step-by-step directions to the reporting and data entry process as well as teleconference/webinar training opportunities every six months prior to reporting.

Background on SART. AoA and CMS, together with our technical assistance providers, developed the Semi-Annual Reporting Tool (SART) for national collection of Aging and Disability Resource Center grantee data. This web-based system was first used by ADRC grantees in 2005 and has been updated and revised as the ADRC initiative has grown and evolved. Evaluation and analysis of these data have resulted in an increased understanding of outcomes and strategies that are effective in operating single entry point systems, partnering across aging and disability systems, streamlining eligibility determination processes for public programs, and carrying out other ADRC functions. The data reported by grantees through this system has been successfully used by states and federal agencies to demonstrate program results and work toward long –term sustainability of the ADRC program.

Exhibit 1. Major Narrative Topics for State-Level ADRC Reporting and Sub-Topics

Grantees will be notified of any changes made to the SART going forward. Potential modifications for future reporting cycles are included here in italics.

1	**ADRC Design, Development and Implementation** o Selection of program sites, program site management and operations: o Advisory board activities and consumer involvement:
2	**ADRC Expansion and Sustainability** o Securing state funding, support from state leadership and/or legislative support for the ADRC: o Securing Medicaid reimbursement (please consider Federal Financial Participation for Medicaid

3	**Information, Referral and Awareness** o Developing and/or maintaining comprehensive resource database with disability, aging and private-pay resources: o Reaching out to and serving private paying consumers:
4	**Options Counseling and Assistance** o Development of options counseling protocols, standards, and training programs: o *Populations receiving options counseling:* o *Where and in what circumstances options counseling is offered:*
5	**Streamlined Eligibility Determination to Public Programs** o Streamlining the financial eligibility application processes for Medicaid and other public programs: o Streamlining the clinical/ functional assessment processes for Medicaid and other public programs: o Developing universal assessment instruments
6	**Care Transitions and Care Coordination Models** o Partnerships with critical pathway providers including hospitals, nursing facilities, physicians offices: o Administering or partnering with evidence-based hospital discharge planning / care transition programs, *specifying model used*: o ADRC involvement with and support of Money Follows the Person and other nursing facility transition initiatives:
7	**Quality Assurance and Continuous Improvement** o IT/MIS development or enhancement to support ADRC functions including I&R/A, public web-based resource directories, service tracking, client tracking, data sharing with partners o Ongoing quality improvement activities o Recent evaluation reports, analyses, survey findings and other materials
8	**Partnerships** o Partnerships across aging and disability networks o Type of partners and partnership activities (e.g. co-location, MOU, written protocol)

Exhibit 2. Data Elements for Program-Level ADRC Reporting

Grantees will be kept informed of any changes made to these data elements going forward. Potential modifications for future reporting cycles are included here in italics.

	Program Site Opening, Service Area, and Population
1	Expected "Opening" or "Kick-off" date of this program site, if not open yet
2	Actual "Opening" or "Kick-off" date of this program site
3	Service area of program site (names of counties served, region or MSA)
4	Total resident population in the service area of this program site

	Model and Operating Organizations
5	How many operating organizations are involved in the day-to-day operations of this Program Site, performing some or all ADRC functions?
6	Operating Organization Name (space for up to 8)
7	Operating Organization Type (space for up to 8)
8	Services and Functions offered as part of the ADRC a) Outreach and Marketing b) Information and Referral/ Assistance c) Short Term Case Management d) Benefits Counseling e) Options Counseling f) Support Brokering (or Options Counseling for Participant-Directed Services) g) Planning for Future LTC Needs h) SHIP Counseling i) Peer Counseling j) Adult Protective Services k) Skills Training l) Advocacy m) Care coordination/care transitions programs n) Nursing facility transitions *o) Local Contact Agency (for MDS 3.0 Section Q)* p) Screening/Intake or Medicaid or Other Public LTC Programs q) Pre-screening for Nursing Home Admission r) Conducting Level of Care Assessments s) Assisting to Complete and/or Submit Financial Eligibility Applications t) Making Financial Eligibility Determinations u) Case Management for Medicaid HCBS Waiver v) Case Management for State-funded LTC Programs w) Assisting with Medical or Pharmaceutical Assistance x) Caregiver Support Services (such as grandchildren helping grandparents) y) Prevention, Health Promotion, or Risk Reduction Programs z) Employment Services or Service Coordination aa) Housing Services or Service Coordination bb) Assistive Technology or Home Modification Services cc) Transportation Services or Service Coordination

dd) Older Americans Act Services not otherwise listed (e.g. Meals on Wheels)
ee) Other

	Operating Budget and Staffing
9	Total annual ADRC program site operating budget
10	How many organizations are included in this budget figure?
11	Total No. of FTE
12	Total No. of FTE by Job Category a) I&R/A Specialists or Operators b) Nurse Case Workers / Options Counselors c) Other Case Workers / Options Counselors d) Benefits Counselors *e) Hospital Discharge Transition Coaches* *f) Institutional Transition Coordinators* g) Financial Eligibility Workers h) Training and Outreach Staff i) IT/ MIS Staff j) Management k) Administrative Support Staff l) Consultants m) Other
13	Minimum Qualification Required for Each Job Category
14	No. FTE who are AIRS certified

	Participant-Direction
15	Briefly describe the extent to which your ADRC is involved in participant-directed long-term services and supports programs?
16	Please specify which programs (e.g. Community Living Program, state-funded HCBS program, Cash and Counseling)
17	Can participants in these programs: a) Hire and manage their own staff b) Use their individual budget funds to purchase both goods and labor services c) Both d) Other
18	Please indicate specifically how your ADRC is involved in these programs by indicating what functions the ADRC performs (check all the apply): a) ADRC options counselors are trained about participant-directed programs as a service option b) ADRC staff refer potential participants elsewhere for screening / assessment / intake c) ADRC staff conduct initial screening / intake d) ADRC staff perform assessments of potential participants

e) ADRC staff (or staff co-located with the ADRC) determine eligibility for consumer-directed programs
f) ADRC staff provide support brokerage / consulting / care coordination for participants
g) ADRC provides / contracts to provide financial management services
h) ADRC maintains list of individual providers available in the area
i) ADRC maintains/administers worker registry
j) Other functions

	Total Contacts to the ADRC
19	Dates between which these data were collected a) Start Date b) End Date
20	Total Contacts made to ADRC during this period (calls or walk-ins)
21	Contacts by Type a) Contacts by Consumers b) Contacts by Caregivers c) Contacts by Professionals d) Contacts by Others (not consumers, caregivers, or professionals) e) Unknown Contacts by Type

	Total Clients (Unduplicated)
22	Total ADRC Clients
23	Clients by Age (Unduplicated, all ages) a) No. of ADRC Clients Aged 60 and Over b) No. of ADRC Clients Under Age 60 c) No. of ADRC Clients Age Unknown
24	Clients by Disability Type (Unduplicated, all ages) a) No. ADRC Clients with Physical Disabilities (all ages) b) No. ADRC Clients with MR/DD/ID (all ages) c) No. ADRC Clients with Mental Illness (all ages) d) No. ADRC Clients with Traumatic Brain Injury (all ages) e) No. ADRC Clients with Dementia (all ages) f) No. ADRC Clients with Multiple Disabilities (all ages) g) No. ADRC Clients with Unspecified Disability (all ages) h) No. ADRC Clients with No Disability (all ages) i) No. Unknown ADRC Clients (no information about disability)
25	Clients by Income Level (Unduplicated) a) No. ADRC Clients - Low Income b) No. ADRC Clients - Not Low Income c) No. ADRC Clients - Income Level Unknown
26	Clients by Type of Assistance Provided

OPTIONS COUNSELING

a) No. ADRC Clients provided Options Counseling (in all settings and situations)
b) No. ADRC Clients provided Benefits Counseling (as part of Options Counseling)
c) No. ADRC Clients provided Assistance with Long-Term Care Futures Planning (as part of Options Counseling)

CARE COORDINATION/TRANSITION

a) No. individuals assisted with hospital discharge
b) No. individuals assisted with transition from nursing facilities into the community
c) No. individuals assisted with transition from ICF/MR into the community
d) *No. individuals assisted with transition from other institutional setting (e.g. residential rehabilitation)*

ELIGIBLITY DETERMINATION

a) No. Clients assisted with process of applying for Medicaid
b) No. ADRC Clients who received comprehensive Level of Care Assessment (performed by ADRC staff or referred for assessment by ADRC staff)
c) No. Clients receiving Medicaid eligibility determination (either positive or negative)

Clients Referred from "Critical Pathway" Sources:

a) No. Clients referred for ADRC services by nursing facility
b) No. Clients referred for ADRC services by ICF/MR
27 *c) No. Clients referred for ADRC services by hospital*
d) No. Clients referred for ADRC services by physician's office
e) No. Clients served referred by some other source
f) No. Clients with unknown referral source (remainder of all Clients)

Referrals to Public and Private Services

a) No. Clients referred to or given an application for Medicaid or another public program including Older Americans Act, Medicare, Food Stamps, TANF, Social Security (SSI or SSDI), Veteran's
28 Affaiirs, and state funded programs
b) No. Clients referred to some other type of service (non-public services, resources or program)
c) No. Clients that were not referred to any type of service
d) No. Unknown Clients (remainder of all Clients)

LTSS System Outcomes:
Average Monthly Public LTC Program Enrollment

Average Monthly Public LTC Program Enrollment in WHOLE ADRC SERVICE AREA (should include ADRC Clients and might include Non-
29 ADRC Clients)

a) Average number of Individuals enrolled in Medicaid HCBS Waivers in ADRC Service Area each month

	b) Average number of Individuals enrolled in Medicaid residing in institutions in ADRC Service Area each month c) Average number of individuals enrolled in other public LTC programs in ADRC Service Area each month d) What HCBS Waivers are included above (e.g. aged and disabled, MR/DD)? e) What other public LTC programs are included above?
	Total New Public LTC Program Enrollment
30	Total New Enrollment in WHOLE SERVICE AREA in Public LTC Programs (ADRC Clients and Non-ADRC Clients) a) No. of individuals newly enrolled into a Medicaid HCBS Waiver this reporting period in ADRC Service Area b) No. of individuals newly enrolled into Medicaid institutional services in ADRC Service Area this reporting period c) No. of individuals newly enrolled into other public LTC programs in ADRC Service Area this reporting period d) What HCBS Waivers are included above (e.g. aged and disabled, MR/DD)? e) What other public LTC programs are included above?
31	Total New Enrollment among ADRC CLIENTS ONLY in Public LTC Programs (including individuals enrolled by ADRC staff and individuals referred for assessment/application by ADRC staff) a) No. of ADRC Clients newly enrolled into a Medicaid HCBS Waiver this reporting period b) No. of ADRC Clients newly enrolled into Medicaid institutional services this reporting period c) No. of ADRC Clients newly enrolled into other public LTC programs this reporting period d) What HCBS Waivers are included above (e.g. aged and disabled, MR/DD)? e) What other public LTC programs are included above?
	Partnership
32	Total No. of Formal Partnerships
33	Type of Partnerships (co-location, MOU, contract, written protocol, cross-training) and Types of Partners (33 different types of organizations listed)

Attachment N: Definitions

For purposes of this Announcement, an "**aging services provider organization**" is an organization that is currently operating a program that serves older adults and is funded (at least in part) through the Older Americans Act. A Native American Tribal Organization funded under Title VI of the Older Americans Act may be included as an aging services provider under this grant announcement.

Aged (or Older adult Person): As defined in the Older Americans Act, "an individual who is 60 years of age or older."

Disabled: As defined by the American's with Disability Act Statutory Definition -- With respect to an individual, the term "disability" means (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment. 42 U.S.C. § 12102(2); see also 29 C.F.R. § 1630.2(g). A person must meet the requirements of at least one of these three criteria to be an individual with a disability under the Act.

A **consumer** is defined as a person of any age or disability who seeks to reside in the community with the support of public funding. Persons included are patients being discharged from hospitals to rehabilitation facilities, nursing homes ICF-MR and other types of institutional settings.

Person-centered Planning is defined as a plan that empowers people with disabilities by focusing on the desires and abilities of the individual. Person-centered Planning involves a team of family members, friends, professionals and most importantly, the individual. The individual chooses their team members. This team then identifies the skills and abilities of the individual that can help them achieve their goals of competitive employment, independent living, continuing education, and full inclusion in the community. They also identify areas in which the individual may need assistance and support and decide how the team can meet those needs. While it is recognized that not all of the elements of a complete person-centered plan can be achieved prior to discharge from the hospital, many elements can be addressed. Elements, such as working with the consumer to develop the most independent living arrangement and providing assistance and supports that are desired by the consumer are included. The consumer with involvement of family members, professionals and others work toward the ultimate discharge plan goal of living as independently as possible with home and community-based services.

Centers for Independent Living (CIL): (1) Center for independent living. The term "center for independent living" means a consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that – (A) is designed and operated within a local community by individuals with disabilities; and (B) provides an array of independent living services such as information and referral, peer counseling, advocacy, and independent living skills training.
(2) Consumer control. The term "consumer control" means, with respect to a center for independent living, that the center vests power and authority in individuals with disabilities.

Other Disability Organizations defined as: organizations that serve individuals of all ages and disabilities; this is not an all inclusive list. (i.e. Centers for Independent Living, Easter Seals, United Cerebral Palsy, The ARC, Developmental Disabilities Councils, Vocational Rehabilitation Programs, Protection and Advocacy organizations, Paralyzed Veterans of America, The Parent Training Centers).

State: Refers to the definition provided under 45 CFR 74.2 any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments.

Community Re-integration Coordinators: CIL employees specializing in nursing home transitions and re-integration back into the community with services and supports.

Single Entry Point (SEP) as: a system that enables consumers to access long-term and supportive services through one agency or organization. In their broadest form, SEPs perform a range of activities that may include information and assistance, referral, initial screening, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring, and periodic reassessments. SEPs may also provide protective services. [20]

A "**One-Stop**" system must be designed so that the consumer only has to go one place or make one phone call to access all ADRC services. Through that one contact, the consumer should either directly receive all the information or services they need or be seamlessly connected with all the information and services they need. One of those ways is to build an integrated/centralized system so that all the functions and services for all the populations served (e.g. aging and disability populations) are offered by one organization in a service area.

One Stop Access to Public Programs: performs these functions, along with information and assistance, through a simple, convenient, single contact point. The program may involve more than one entry point (or "site) at the community level (e.g., different access points for different populations) so long as (a) each access point is authorized and performs all functions of a single point of entry, (b) the process of access experienced by individuals is uniform across all entry points, and (c) individuals do not access long-term support services through admission points that do not perform all functions of a single point of entry. One-stop access to public programs also ensures that individuals have the information they need to make informed decisions and that individuals reliant on public support are not admitted to service by alternate means or by direct admission through an individual provider of services.

In "**No Wrong Door"** entry system, multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity.[21] Susan Reinhardt described "no wrong door" as more of a philosophy

[20] Robert Mollica and Jennifer Gillespie, *Single Entry Point Systems: State Survey Results.* Rutgers/NASHP Community Living Exchange Collaborative, August, 2003.
[21] Allison Armor-Garb, *Point of Entry Systems for Long-Term Care: State Case Studies*, prepared for the New York City Department of Aging, 2004.

than a “model”. It is a philosophy of public service that strives to give consumers access to services regardless of how or where they first encounter the system. The goal of no wrong door is to create a system where social services wrap themselves around the individual and provides seamless access to information on available options. It is philosophy that can support many different models for helping people get the information they need to get services and supports

Care coordination is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

Broad definition of **Options Counseling** is an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term support choices in the context of the consumer’s needs, preferences, values, and individual circumstances.

Benefits Counseling: The provision of information and assistance designed to help people learn about and, if desired, apply for public and private benefits to which they are entitled, including but not limited to, private insurance (such as Medigap policies), Supplemental Security Income (SSI), Food Stamps, Medicare, Medicaid and private pension benefits. For purposes of this program, Benefits Counseling funded under the Older Americans Act that is provided to individuals who need help in order to remain in the community, is included in this definition.

Counseling and Referral to Help People Remain in the Community: The provision of comprehensive and accurate information on services and programs that can help people to remain at home and in the community. These include (a) direct services (such as home and community-based waiver programs, home health, personal care, case management), (b) generic community sources of help (such as nutrition programs, prescription drug programs, health promotion and disease prevention programs, transportation services, home repair programs, real property tax relief), and public or private insurance (such as long-term care insurance, Medicare, Social Security Disability Insurance (SSDI), and SSI). For purposes of this program, counseling and referral activities designed to help individuals to remain in the community that are funded under the Older Americans Act are included in this definition.

Coordination with Medicaid Financial Eligibility Determination: The determination of financial eligibility for Medicaid may take place either at the ADRC or off-site. Regardless of where it takes place, the ADRC must assure that the process is coordinated or integrated with the functions of the ADRC so that it takes place in an expeditious manner that avoids duplication of effort for individuals, their families and agency workers. The result of this coordination should be a seamless system of long-term support as experienced by the individual.

Eligibility Screening: Is a non-binding inquiry into an individual’s income and assets, as necessary, and other circumstances in order to determine probable eligibility for programs,

services, and benefits, including Medicaid. This screening should be provided to all individuals who may be eligible for publicly funded programs.

Crisis Intervention: ADRC programs must be able to respond to situations where short-term assistance is needed to support an individual until a plan for long-term support services can be put in place. For example, an individual whose existing support system has fallen apart may need immediate support to assist them while a more comprehensive plan is developed and implemented. If an individual is in danger to self or others, ADRC will refer to, and coordinate with, existing supports such as Adult Protective Services, in accordance with state laws and agency procedures.

Information on Long-term Support Options: The information available must be comprehensive, objective, up-to-date, citizen-friendly, in an accessible format and cover the full range of available options, including in-home, community-based, and institutional services (including nursing home services). The information must cover options that people will use immediately (such as Medicaid services) to long-range options (such as private long-term care insurance). The information must also cover programs and services that support family caregivers, as well as any special options in the state to maintain independence or direct one's own long-term support services.

Long-term Support Services: Long-term support refers to a wide range of in-home, community-based, and institutional services and programs that are designed to help older adults and individuals with disabilities or chronic conditions with activities of daily living or instrumental activities of daily living. Public long-term support services are those administered by a governmental entity. For purposes of this program, long-term support services under Medicaid include home health, personal care, targeted case management, home and community-based waivers under section 1915(c) of the Social Security Act, nursing facility services, and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). Long-term support services under the Older Americans Act include personal care and other in-home services similar to those provided under section 1915(c) of the Social Security Act. Long-term support services under state-only programs include home health and personal care. Finally, for purposes of this program, the state may include in the definition of long-term support services any other publicly-funded service which the state determines should be accessed through the assessment process of the ADRC.

Programmatic Eligibility Determination: A determination of the publicly supported benefits or services to which a person is eligible, based on non-financial criteria. This may require a formal assessment to determine the full scope of the individual's needs. It may include a functional assessment of the individual's current health conditions and provide a situational assessment of the client's environment, available resources, and current support. For Medicaid services, this function includes the "Level of Care" determination process.

Public Education and Outreach: Activities related to ensuring that all potential users of long-term support (and their families) are aware of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.

Informal Supports are defined as family members, neighbors or friends whose regular assistance helps the consumer reside in the community. The consumer chooses support from the family caregiver(s) as part of the PCP process for community living.

Informal Community Network is defined as the consumer's current and potential friends and other social connections that do not provide continual care to the person but provide social support and may help intermittently with tasks and chores.
Helpful information may be accessed at the following websites:

- *Caregiver Assessment: Principles, Guidelines & Strategies for Change. Vol. 1.* April 2006. http://www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf
- *Caregiver Assessment: Voices and Views from the Field. Vol. II. April 2006.* http://www.caregiver.org/caregiver/jsp/content/pdfs/v2_consensus.pdf
- *Caregivers Count Too. An Online Toolkit to Help Practitioners Assess the Needs of Family Caregivers.* June 2006. http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1695

- Feinberg, Lynn Friss. *The State of the Art: Caregiver Assessment in Practice Settings.* 11/02. http://www.caregiver.org/caregiver/jsp/content/pdfs/op_2002_state_of_the_art.pdf